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Facilitators and Barriers for Implementing Home Visit Interventions to Address Intimate Partner Violence: Town and Gown Partnerships

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Abstract

Pregnant women involved in violent relationships represent a population that is vulnerable for poor pregnancy and infant outcomes on several levels. This article describes development of a ‘town and gown’ partnership to assist pregnant women in violent relationships. Barriers and facilitating factors for research and home visit nurse partnerships working with this vulnerable population were identified by home-visitor participants in a qualitative focus group session. Methods utilized to develop and maintain the reciprocal relationship between the community (town) and academic researchers (gown) are described.

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Keywords

Intimate partner violence; domestic violence; community partnership

Introduction

It has been estimated that nearly 5.3 million incidents of intimate partner violence (IPV) occur every year in the United States to women ages 18 and older resulting in nearly 2 million injuries and 1,300 deaths [1]. IPV has been linked with both immediate and long-term health, social, and economic consequences. Immediate health consequences women experience range from minor injuries to major long term injuries, as well as psychological or emotional problems, suicidal behavior, and even death [1]. These women have also been shown to have a higher incidence of engaging in alcohol, tobacco, and substance use and abuse; unhealthy dietary behaviors such as fasting, vomiting, and overeating; and overuse of health services [1].

Social consequences of IPV can include women being isolated from their social networks and restricted from access to services due to controlling behavior and restriction of activities by the abusive partner. In the United States, the economic impact of IPV costs billions of dollars every year in direct costs for medical and mental health care and in indirect costs related to lost productivity and death [2]. Research has also identified that women experiencing IPV are more likely to be unemployed, and receiving public assistance [3].

Research examining rates of abuse in rural areas is comparable to rates present in the general population [4]. However, rural women may be at an even higher risk for disparities in health care not only from the abuse but also other barriers which exist unique to their living situation and environment. These barriers: poverty, underinsurance or lack of health insurance, lack of public transportation, fewer healthcare providers, lack of childcare, communication difficulties, decreased job and advanced education opportunities ultimately impact their access to care [5].

Geographical isolation often makes it difficult for rural women experiencing IPV to leave and get help, as well as for law enforcement agencies to respond [6–8]. When a woman does find a way to leave, her choices are often limited and the choice to go to a shelter may require going to an unfamiliar and often frightening urban setting. Otherwise, she may remain in the community where the care providers and consumers know one another, making the fear of lack of anonymity a barrier to her decision on leaving [6]. Women and children who are geographically isolated and within a patriarchal social structure contribute to a social context that perpetuates male violence and social control of women [9,10].

To address health disparities within vulnerable populations, university (gown) and community (town) partnerships have been successfully used [11–14]. A university, particularly a land-grant institution, has a commitment to service within the community. In addition, the National Institute of Health (NIH) has established a roadmap to guide research initiatives from bench to practice. Town and gown partnerships help to drive research progress toward practice at a faster pace. The use of interdisciplinary partnerships and public-private partnership collaborations increases utilization of available resources from all members of the collaboration [15].

Working collaboratively with the commitment to improve health, town and gown partnerships provide a mechanism through which knowledge can flow in both directions resulting in improved health outcomes. These partnerships empower the community members with new resources and knowledge and assist in future action planning and social change [11,13,14,16,

17]. In exchange, the communities can provide university members with knowledge about the community that can help university partners to target their efforts in minimizing disparities [11,12,16,17]. The purpose of this article is to describe one town and gown partnership established to address the health disparities of women experiencing intimate partner violence and the children who are exposed to that violence. A focus group study was conducted to identify the barriers faced by the “town” partners as they work with victims of IPV. Findings from this study are crucial to overcome issues home visitors face when working with this vulnerable population of women and children.

The DOVE Story

All research has an underlying story. The Domestic Violence Enhanced Home Visitation (DOVE) research study began, as many do, with a question. If two research-based interventions known to improve pregnancy outcomes - home visitations [18–21] and an evidence-based structured IPV intervention [24] - were combined, would there be a reduction in maternal exposure to intimate partner violence, and thus decreased infant exposure to IPV and an improvement in her infant’s health and developmental outcomes?

Early home visitation has been an essential strategy in community health practice that has been shown to improve the health and outcomes of families as well as prevention of child maltreatment [19,22]. Research has shown that mothers who were visited by Nurse-Family Partnership (NFP) nurses were less likely to be reported for child abuse [18,23]. Even without systematic assessment and intervention, nurses who visited families in their homes reported significantly less IPV after 4 years [21]. The DOVE study builds upon these findings by adding a structured nurse home visitation intervention for IPV.

Utilizing Parker and McFarlane’s evidence-based IPV empowerment intervention[24], the DOVE study provides prenatal visitors (town partners) with a research driven strategy (gown intervention) to use with pregnant women in their caseloads who are experiencing current intimate partner violence. This intervention includes a structured brochure with information addressing the cycle of violence, risk factors associated with increased risk of homicide, options available to the woman, safety planning, and IPV resources specific to their locale, as well as national hotline phone numbers[25]. For the DOVE study, the home visitors are trained in the use of the brochure by the gown partners. Home visitors can individualize the brochure to meet each woman’s special needs by allowing each woman to share her story. The brochure can then be used to focus on the areas the woman appears to have a particular need or interest in. This empowers the woman through the ability to share her story and make choices/decisions regarding the information they are most interested in [26].

The idea of utilizing proven methods to improve outcomes for pregnant women experiencing IPV through a town and gown partnership seemed ideal. The universities participating in the grant project forged a strong partnership with the State Health Department at the rural site and planned to use the prenatal home visiting programs funded by the department. After receiving notification of funding, the DOVE research team (gown) began the partnership with the town partners by training the home visitors from the twelve participating counties’ prenatal home visitation programs in March of 2006. (See Table 1 for details of town/gown activities). Home visitors from these counties included registered nurses, licensed practical nurses, social workers, and lay home visitors. The initial one day training workshop hosted by the State Health Department featured Dr. Jacquelyn Campbell, a leading nurse researcher in the area of IPV, who focused on the role of the home visitor in screening and intervening with pregnant women experiencing IPV. This workshop was attended by 75 home-visitation staff, representing all participating counties in the state funded prenatal home visitation program.

After the IPV overview training in March (2006), a series of trainings at the various community sites were conducted by the principal investigators and consultant of the grant between March and July (2006). The purpose of these trainings was to prepare the home visitors (HVs) in the research protocols pertaining to the DOVE study. Final approval of the Certificate of Confidentiality from the federal government was not obtained until October 2006, so there was a prolonged period between training and being able to begin recruitment for the study. To refresh the home visitors in the protocols and procedures of the research study, a telephone conference call was conducted. Four different days and times were offered for the HVs, and the State Health Department made it known that all home visitors were expected to participate in at least one of the calls.

Recruitment for the study began in January 2007. All HVs were trained in accordance with the research protocol for screening and referral of women to the DOVE study. The HVs (town) screen all women in their prenatal case load for IPV at every home visit using the Abuse Assessment Screen (AAS) [27] and the Women's Experience with Battering (WEB) [28] instruments. Women who are pregnant and screen positive for current intimate partner violence are asked by the home visitor for their written permission to forward their name and contact information to the research team (gown). The research team then contacts the woman and arranges a convenient time and place to meet to explain the study and obtain consent for participation if she agrees.

Even though the research team maintained regular contact with the home visitors through a variety of methods – phone calls, personal contacts, emails, and a monthly newsletter regarding the DOVE study (Table 1), after several months of recruitment referrals were coming in very slowly. The explanation given by the HV's for the small number of referrals was the lack of women positive for abuse within their caseload. This did not seem plausible when the research team had found rates as high as 33% current abuse working with a similar population who were enrolled in smoking cessation intervention study in the same rural areas [29]. It was hypothesized by the gown partners that either the home visitors were unable to screen the women or that the women were not willing to disclose the abuse to the HV who lived in the same rural community. Two strategies were implemented by the gown partners to counteract these problems in order to increase recruitment.

First, IRB approval was obtained that all pregnant women (regardless whether she screened positive or negative for abuse) would be asked by the home visitor to give her written permission to have her name and contact information given to the research team. The research team would then re-screen all women referred and consented for IPV using the AAS and WEB instruments. Women who were negative for abuse would be dropped from the study and those who were positive would continue in the study as originally planned.

Another strategy to improve overall recruitment was holding another two-day workshop focusing on IPV. This work-shop was hosted by the State Health Department in July 2007. The workshop was an ideal forum for the DOVE research team (gown) to interact with the HVs (town) in a structured way to tease out issues the home visitors were having in screening and intervening with women experiencing IPV. Both quantitative and qualitative methods were used to gain a better understanding of the problems and successful strategies that were present amongst the town partners (HV's). IRB approval was obtained from the State Health Department IRB as well as the university IRB to conduct this quality improvement evaluation. The results of the qualitative findings are presented below.

Methods

Sample

Home visitors from all twelve counties participating in the prenatal home visiting programs were invited for the first day of the workshop focusing on general issues of screening women for IPV. Thirty-one home visitors representing the twelve counties were present on the first day and all but one was female. On the second day, only HVs ($n = 23$) from the six intervention counties participated in the workshop which focused entirely on delivering the DOVE intervention to women experiencing IPV. On the first day the HVs attending were invited to complete a questionnaire anonymously. Twenty-six HVs, (nurses, social workers and unlicensed home visitors), filled out the questionnaire. The mean age of the participants completing the survey was 46 years and educational experience ranged from 17.4% with a high school/GED education to 26% with a master's degree. On the second day, the HVs from the intervention counties were also invited to participate in focus groups. NOTE: Three home visitors present on Day 2 were not present on the first day so did not have the opportunity to participate in the survey questionnaire. It is not known how many of the second day participants would have been among those completing the questionnaire on the first day.

Procedure

Prior to the end of the first workshop day, all attendees were invited to complete an anonymous questionnaire that included basic demographic information, issues related to IPV, including personal and professional experience, and a series of questions measuring the HV's knowledge, attitudes and beliefs regarding IPV. On the second day, attendees present were invited to participate in focus group discussions. Participants were assigned to a focus group by numbering off from one to four. Pairs of DOVE team members led four simultaneous focus groups which included four to six home visitors. Questions that were asked during the focus group discussions are listed in Figure 1. No one refused to participate in the focus groups.

One DOVE team member was designated as leader of the group – asking the questions and using cues as needed that facilitated participants' discussion of their perceptions and concerns. The second DOVE team member was responsible for recording and monitoring the time assuring that each question would have sufficient time for discussion. Sessions were recorded and later transcribed. Descriptive content analysis of themes within each question was used to analyze the findings. Barriers and facilitators were noted within each of the questions asked during the focus group session. Sub-categories were also noted within the themes adding depth to the data describing HV experiences working with pregnant women experiencing IPV. A coding matrix was reviewed by several DOVE team members to obtain consensus on recurrent themes.

Results

Eighty-four percent ($N = 23$) of the HVs participating in Day 1 of the workshop completed the survey questionnaire. From the survey the HVs own personal experience with family violence was obtained. Table 2 presents the type of abuse experienced by the home visitors. Personal experiences with physical, sexual, and emotional abuse were reported by many. Physical abuse was reported to have occurred with 16% ($n=4$) of the HVs during their childhood, with 28% ($n=7$) reporting having witnessed it during their childhood. Twenty four percent of the HVs ($n=6$) experienced physical abuse as adults. Sexual abuse occurred with 21% ($n=5$) in childhood, with 9% ($n=2$) witnessing it in childhood. As adults, 13% ($n=3$) of the HVs had experienced sexual abuse. Twenty percent ($n=5$) of the HVs reported emotional abuse during childhood, with 32% ($n=8$) having witnessed it during their childhood, and 24% ($n=6$) experienced emotional abuse as adults.

The mean age of participants identified as abused ($n = 9$) was 45 years of age, and 47 years for non-abused HVs ($n = 14$) (Table 3). The HVs who identified as being abused had an average of 17 years of education, while those non-abused had an average of 15 years. The average numbers of years working in health care for the abused and non-abused HVs were 9 and 13 respectively. On the average, HVs identified as being abused had worked 5 years with IPV and had completed 5 trainings related to the issue; home visitors identified as non-abused worked an average of 3 years with IPV and had completed 2 trainings.

Focus Group Results

A summary of barriers and facilitators to working with women who are victims of IPV as noted by the HVs during the focus group session is provided. As appropriate, supporting dialogue from focus group participants is included.

Barriers—Barriers identified by HVs dealt primarily with their own emotions that revolved around stress and frustration. They indicated that feelings of inadequacy, whether inadequacy related to assessment of their client's risk/experience of IPV or feeling inadequately prepared to assist the client when IPV is identified, were a source of stress.

"I think that my struggle is feeling a little inadequate and not knowing what to say, I can encourage them and tell them that what is happening is not okay. ...I don't know the perfect thing to say, as others said taking it home and being so upset and thinking I don't know how long you can do this type of work since it effects me so much. So a variety of emotions."

Other participants noted feeling stress when the client divulged that she was a victim of IPV,

"I feel that it is stressful and challenging to find immediate resources and solutions especially if the woman cannot leave ... and I feel kinda powerless and helpless."

Stress and frustration also occurs when the HV is attempting to control her own emotions while working with the client.

"My stress comes into the point of being able to control my feelings ... I wept and I felt bad about that because we are trained not to cry with the family because the concern is that you're going to make her feel bad. Which in one sense it did make her feel bad but I guess in a good sense it shows her that I am very sympathetic and that I feel her pain in some sense and I am also concerned that as I continued to work with this mom if I will be able to handle the emotional part of it."

Another identified stressful barrier is discomfort of the unknown variables in the environment. One HV described this as:

"I am comfortable working with the woman - uncomfortable at times in the home - but comfortable with the women. Especially the first visit, not knowing the layout, not knowing the abusers schedule where he might be or where he might come from."

Frustration was also described by a few HVs as a barrier when working with victims of IPV. They felt frustrated when their clients admitted to abuse, sometimes repeatedly, yet would not take their suggestions to increase their safety.

"...but it becomes kinda frustrating because they repeat their story over and over and we don't seem to be getting anywhere."

Some HVs stated their clients would show signs of abuse, yet were hesitant to admit, even when confronted by the HV.

"I said that is very unusual bruising and you don't normally see bruises like that do you know how it happened? And then she said that 'No, no I don't know how I got

them'. Then I described them and I put my fingers into the bruises and said that it looks like that someone really pressed their hands hard into your arm – that is what it looks like to me..."

To be fair, it should be noted that some of the HVs described working with IPV victims as rewarding.

"Feeling rewarded that you were able to make a difference even if she didn't leave or do something else but giving her those options."

"...it makes me feel good to be there and allow the mom to let her air her issues, and encourage her in any way I can, and just be a very supportive person for her because I know that most of my moms are very isolated..."

Another barrier to having HVs screen for IPV involves the fears and comfort level of the HV with initiating conversations dealing with violence. HVs in the focus group session admitted to having feelings of fear associated with clients admitting to when they screen for violence. The fears included: "... *making a fool of myself*", fear of inability to help client appropriately, fear of offering help that is not taken, and fear for themselves and their clients were vocalized by the HV participants.

"I think that it is just a hard topic to talk about it in general, and stumbling over my words and making a fool of myself for not knowing where to go with it in the conversation and getting lost in my words a lot of time."

"I think that one of the concerns that I have seen over the years is that once the client has disclosed and you begin to talk to her about what to do whether if she feels like she is in danger or eminent danger or what. And then you offer those measures to her or those ideas and then they don't do anything. And then you feel hopeless like what do I do now because they don't want to take that."

"...so you don't want to cause more harm – so you do not want to push too far – push them too much too soon and you don't want them in danger or yourself in danger."

It was obvious that the HVs are eager to assist their clients any way necessary, but are reluctant to act if they perceive their actions could potentially cause the client more harm. Not knowing about the abuse seemed to be perceived by the HV as having more freedom to assist the client with other health disparity barriers – prenatal care, medical needs, environmental health etc. Once IPV was identified, the HV was obligated to address the issue, which was noted by them as an awkward situation, though most of the HVs agreed that it was significantly important.

Facilitators—Many of the HVs in the focus groups admitted to previously or currently having women in their case loads who had admitted abuse. HVs with this experience were helpful in identifying methods they have used to improve communication with their clients, increasing the potential that the client will be open to talking about the abuse. Admitting to the abuse allows the HV to provide the client with information, materials and resources that may be helpful.

Building a good rapport with the client was the most mentioned strategy to open communication. Many HVs described stories where clients only admitted to abuse in their relationship after many visits by the HV, sometimes after many years as their client.

"You just build a trust with them. You build a friendship with them. They get to know you and you know them. And it's just going to happen over time, you may not get it the first few weeks or that first month but you are going to get it in time – that relationship."

“...it just takes some time and the families I work with I get them for two years and we have a long cycle and it is going to happen again and again and so you want us to fix it now and that is not the way I look at these things. They are making some life changes and it just takes some time and trust.”

Other participants note the use of voice inflection and non-verbal cues as very important when working with IPV victims. Being careful not to intimidate, appear to persuade, or belittle women in their case load helps them gain the respect needed for women to feel comfortable discussing difficult topics such as abuse.

“I work with teens so I really have to watch my facial expressions and they are looking at my reaction – and so many times I have to mention it in casual conversation and usually they will respond and let me know sometimes on the first visit and sometimes a bit later.”

“I would say that eye contact is so much. That when they start the conversation and they can’t look at you directly and you show them that respect that you are listening, then by the end there is, you can tell that they are receptive.”

Barriers working with Gown Partners—When asked about barriers noted within their own experience working with research teams, many HVs at first denied negative issues related to working with research in their job. Many noted that having a research team available was a relief and a good resource for both themselves and their clients. As discussion progressed, a few participants did reveal negative issues related to having their clients in a research study.

The most common negative issue discussed by the HVs revolved around perceived interference or risk for interference by the research nurses with the carefully built relationship between the client and themselves. HVs described fear that their clients would not view their relationships in the same manner since they now knew if she was abused.

“The only concern I have is that when I give this girl this paper and she consents for you guys to call her that she thinks back in her mind and then thinks that she shouldn’t, we shouldn’t visit any more. I have one girl that had consented to be called and we had a pretty good relationship with her and she was getting ready to deliver and she up and left and she didn’t call me... So in the back of my mind I keep thinking that she didn’t call me because I had gotten her hooked up and she hadn’t told me anything before and now I knew.”

One HV was concerned that research involvement and the added responsibilities of participation would overwhelm her clients at a time when they were already stressed.

“Our specific program has a lot of requirements as part of our program so we have issues with overwhelming them with too many people coming into their home ... and so we are asking them to do one more thing and even though they are going to get paid, they get paid with the other things too so it is just one more requirement and it may stress them too much.”

It is interesting that themes identified as negative aspects of having clients involved in research were all framed as negative for the client. No comments were noted as the involvement being negative for the HV. The only comment related to the amount of time needed for the HV to complete the DOVE intervention dealt with the time needed being an inconvenience for the client, not the HV.

It should be noted that previous communication from individuals at various prenatal home visiting sites indicated that one possible rationale for decreased referral rate by the HVs was the fear that DOVE team nurses would ‘take over’ their clients’ care, breaking the carefully

forged relationship the HV had developed with her/his clients. No mention of this barrier was noted during the focus group sessions. Conversely, when probed regarding the topic of ‘feeling like the DOVE nurse would take over’, focus group participants denied this fear.

Discussion

The information obtained from the home visitors participating in this study provides the gown partners with valuable insights about town partners’ perceptions of barriers they face when working with this particular group of vulnerable women and with the research team. Because our town partners hold the key to identifying abused women and thus helping eliminate the health disparities this group faces, it is crucial that we understand these barriers.

One of the main barriers regarding screening for IPV noted in our focus groups, as well as numerous research studies [30–40], is related to the lack of knowledge and training healthcare professionals receive: knowledge related to violence and warning signs; not knowing how to ask about violence; lack of knowledge regarding legal options and social services; and how to help in general. This lack of knowledge seemed to fuel the HVs stress and fear of working with abused women. Our numerous meetings with the HVs and various workshops regarding the DOVE study have attempted to break down this barrier by providing information and special training to allow the HVs to become more comfortable with addressing the topic of IPV. Our experience, however, shows that multiple sessions are needed. Providing the opportunity for the HVs to communicate openly and honestly about their experiences and feelings of dealing with women in abusive relationships, reinforces that the work they are doing is important and the knowledge helps to alleviate some of the fear. The town/gown partnership provides the HVs with evidence-based-knowledge and hands-on-experience needed to assist and empower the women they are working with to make decisions regarding her safety as well as that of her children.

Whether screening for abuse in an institutional setting or rural home visit; providers have expressed their concerns regarding inadequate knowledge regarding the identification and treatment of women experiencing violence as well as IPV resources a provider has available to offer women identified [30,31,35,36,38,40–42]. There are unique barriers experienced by rural providers related to resources such as: law enforcement agencies slow response to reports of abuse due to the distance required to travel to the site of the violence and fewer shelters being available in rural areas [30,31,41–43]. Even when available, rural women are often hesitant to utilize the shelter in their area because of the risk of loss of anonymity. This fear can hinder a woman’s decision to leave her abuser. Providers from both rural and urban settings also express their concerns over offending the woman by asking about abuse. Rural providers may differ in that many times the provider may know the woman she is helping personally, or may know her abuser. This appears to be more of a concern for rural healthcare providers than those in the urban setting where additional resources are available to help provide the anonymity that abused women prefer [31,32,41,42].

Within hospitals and clinics lack of time is cited as a major barrier as well as, lack of privacy for screening, fear of offending the victim/client, inconsistency in screening guidelines, cultural values and influences, lack of support, and nurses’ own personal experiences with violence [39,44–48]. The HVs from our focus groups also expressed fear of offending their clients, being uncomfortable with the screening tools, not knowing what resources were available or what to do if the woman admitted to being abused, as well as disclosing their own personal experiences/history of violence in their lives. It was clear from the focus groups that the women’s well-being was the top concern for the HVs so that when they realized they may be further victimizing a woman by not screening, some of their own fears seemed to dissipate.

Nursing Implications to Screening for Abuse

The personal history of abuse experienced by the home visitors (see Table 2) is similar to current documented rates of abuse in the general population. Nursing care of the victims of abuse can be impacted either positively or negatively by healthcare providers' past abuse experiences. The professional role and culture of healthcare can help to make this care more positive than negative.

Nursing education emphasizes the importance of separating personal values, past experiences, and opinions from professional responses to clients. This neutrality is meant to avoid reacting on personal experiences and viewpoints and imposing them upon others. Empathy is another characteristic of nursing education and forms the basis for a helping relationship [49]. Providing understanding and sensitivity to others' feelings, emotions, or situations may become difficult and nurses may distance themselves when they themselves may be dealing with similar issues. However, it may also be to the client's benefit to receive care from nurses who have also been victims of IPV, since they may be even more sensitive to patients' situations. When reviewing transcripts from the focus groups and demographic survey, several home visitors admitted that their own similar personal experiences influence the care they provide:

"I can say that I have had a family member that has been abused and one thing that I have seen and I know is that you can't make them get out until they are ready...that is one thing that I have seen...I have seen my mom and all kinds of family going over trying and they keep going back so it is a cycle, you can't force anyone until they are ready, you can be there and empathize with them but if they aren't ready they aren't ready."

Limitations of Study and Application to Future Practice and Research

It is important to note that this study is limited in several ways. First, the sample was a convenience sample of home visitors already involved in the DOVE Study. Secondly, the focus group interviews included a time-limit imposed by the workshop schedule and there was a possibility for decreased participation related to group dynamics. In addition, while a strength of the study is the inclusion of HVs from urban, suburban and rural areas, all participants were located in a single mid-Western state, decreasing generalizability to other regions of the United States or globally.

As noted with our HVs, and as previous research has shown, many have both personal and professional issues addressing IPV with their clients. Nurses who have experienced abuse may or may not be as effective in identifying and intervening with patients who are experiencing abuse. More research is needed in this area to determine what effect prior experiences have on nurses' behaviors. Providing assistance to these nurses to acknowledge their own personal emotions, values, and opinions related to their traumatic abuse may allow them to be more successful in assessing, identifying, and intervening with battered women within their individual caseloads.

The DOVE Study's town and gown partnership is one example of how collaboration between researchers and healthcare providers in a rural setting can help each other learn and grow while helping to strengthen and support a climate for social change. This partnership can also enhance the well-being, health, and provision of resources to this vulnerable population of women and children experiencing abuse through evidence based interventions.

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Figure 1.**QUESTIONS UTILIZED IN FOCUS GROUP SESSIONS**

- 1) “What is it like for you to work with a woman whose partner is abusive?”
- 2) “What strategies seem effective in breaking the silence about abuse?”
- 3) “What are some fears home visitors have in initiating conversations about violence?”
- 4) “What issues with your work can you foresee when women in your case-load participate in research studies?”

TABLE 1

Town/Gown Education/Communication Activity Summary for the DOVE study.

Date	Training Event	N= attended
1) March 2006	4-hour IPV training	75 participants, all counties
2) June 2006	3-day training workshop for intervention counties	24 participants, all intervention counties except one
3) Dec. 2006–Jan. 2007	2-hour conference call follow-up training	40 participants, all sites
4) June 2007	1-hour conference call	28 Participants, all sites except Jefferson City and St. Louis
5) July 2007	2-day workshop on IPV	40 participants, all sites except Jefferson City
6) March 2006–	Site visits by DOVE nurses	25 additional site visits completed by DOVE team between all sites July 2007
7) On-going	Other continuing contacts	Email/phone contact 2–4 times/month per communication site DOVE Nest newsletter: monthly since April 2007 sent to all sites Literature provided via email/mail

TABLE 2

Number and Percent of Home Visitor Personal Experience with Abuse.

	Physical Abuse (<i>N</i> = 25)	Sexual Abuse (<i>N</i> = 23)	Emotional Abuse (<i>N</i> = 25)	Total * (<i>N</i> = 25)
Childhood	4 (16%)	5 (21%)	5 (20%)	6 (24%)
Witnessed in Childhood	7 (28%)	2 (9%)	8 (32%)	8 (32%)
Adult	6 (24%)	3 (13%)	6 (24%)	7 (28%)
Number of Individual Women per Category	8 (32%)	6 (26%)	9 (36%)	9 (36%)

* NOTE: Questionnaires with missing data on abuse items were excluded from some analysis

TABLE 3

Descriptive Information from the Home Visitors Completing the Survey.

DEMOGRAPHICS	ABUSED (<i>n</i> = 9)	NON-ABUSED (<i>n</i> = 14)
Mean Age	45	17
Mean Years of Education	17	15
Mean Years in Health Care	9	13
Mean Years Working w/IPV	5	3
Mean Number of Trainings	5	2