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**THE NEXT MILLENNIUM CONFERENCE:
Ending Domestic Violence
Intervention - What works?**

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BOS: kap

INTRODUCTION: ...to this afternoon's program entitled Intervention - What works? I am Olga Becker, and I am the workshop moderator, and I would like to introduce this afternoon's speakers and immediately to my right is Susan Hadley is the founder and former long-time director of Women Kind Support Systems for Battered Women in Minneapolis, Minnesota. Antonia Vann, I'm sorry, is the executive director and founder of Asha(?) Family Services in Milwaukee, Wisconsin. Carol Seaver is coordinator of the Older Abused Womens Program at the Milwaukee Women's Center. She began the program in 1992 as a pilot project. Before this she was director of Milwaukee's Retired Senior Volunteer Program. She has a BA from the University of Milwaukee, Wisconsin. Juana(?) Perez is the facilitator for a Latino Battered Women's Support and Education Program at Mercy Mobile Health Care, chairs Latino Families At Risk Program. Ms. Perez has worked with abused immigrant Latino women since 1992. And our two others moderators are Juana Perez and Felipe Perez. And when you do your presentation if you would introduce yourselves. I'm sorry, you don't have information. And I think we're ready to start.

HADLEY: My name is Susan Hadley. I want to take twenty minutes to talk to you about the Women Kind Program in Minneapolis, Minnesota. Primarily we're going to talk about

the evaluation project that was done evaluating Women Kind, it's client services, and it's training program. We started back in 1996. The contact people, if you have questions on the program content and how it works, I would contact me. If you have questions on the data and the research, for heaven's sakes, contact Lynn Short. Doctor Lynn Short is at the Centers for Disease Control and Prevention. I'm a clinician. I have learned an awful lot about research in the last five years, but basically it is not what I do. Back in 1991, we found that health care providers might and may be the first and only professionals in a position to recognize violence in their patient's lives. This quotation came from a Jama article, the first national article written on Women Kind in December, written by Terry Randall. And I think it was the first exposure that - there's a role for the health care provider. The health care provider is not responding appropriately and how do we help institute change. What we found out is health care intervention is earlier intervention. We are talking about early intervention. We are not talking about screening and assessing most of our patient and clients for Women Kind through the ER. Only twenty percent of our referrals come from the ER. We are located in three hospitals in the twin cities. I would say approximately a hundred and twenty five new contacts each month are referred to the program and what

is absolutely critical to know that if it's early intervention, recovery's a long-term process. The victim of abuse is not going to make immediate changes simply because you screen and assess and identify and say the right words. That will re-orient their thinking. She is not going to immediately go to a shelter and get out of the relationship. And I think that is absolutely so critical for you to understand, and I think many of you do. When you decide to buy a house, clearly you investigate the possibilities. You look at interest rates. You go around and look at houses, and you do this in concert with a realtor and you do find someone to provide you the information you need to buy the house. The victim of abuse doesn't have that luxury. She is looking at ways to stay safe in the relationship and eventually, if appropriate, to leave. But she doesn't have the reality check that you're going to have when you're buying your house. She's far more isolated and for that reason, it's going to take her longer and she's in a very unsafe place.

Now I put out for you incidence and prevalence data not because I want to read it off. And for those of you that need the handouts, we'll make sure you get them when we're finished. The reason I put out four sheets of incidence and prevalence is we looked at physical health, abuse during pregnancy, mental health, adolescent, elder,

gay and lesbian, children, stalking and homicide. The primary reason for giving you this data is simply for you to know that this is a wide spread problem. You're going to see this throughout the health care system. In the hospital I think you are far more likely to see mental health issues in longer term relationships. You're obviously going to see stalking at anytime during the course of a battering relationship. So what I want you to do is you will see data concerning emergency room intervention. You will also notice that's only one small part of what we're talking about. So pick this up when you're finished. It will be right over there. It will give you an idea of the scope of the problem and why intervention needs to take place throughout the health care system.

I actually believe that the medical office public health clinic, private physicians office are a far more likely place to screen and identify victims of abuse. And the reason is you may well have a relationship with your family practice doctor and in many ways the process can be supported better through a family practice setting and a medical setting maybe long before someone gets to the hospital. Most of our referrals through the hospital, a hundred and twenty five a month have come for reasons other than domestic violence. Which means the patient is in there for possibly gall bladder surgery, orthopaedic surgery, a

medical problem, and if you screen, she will acknowledge. Not right away. But if you screen when she is ready. And it's primarily she, although we're seeing more male domestic violence. But if you screen, I promise you sooner or later when that victim is ready, she'll acknowledge to you. The difference is it's on her timetable and not yours and not mine. And that's critical.

Women Kind was started in '86. It is probably the most comprehensive, structured, health care response in the country and it has become a national model. This is the philosophy. Routine assessment and identification combined with early intervention. And I truly believe over time it can result in prevention. It is not going to happen quickly. Progress and process is slow. The vision from the start has been to integrate the issue. And to integrate the issue we need to talk to each other, so this is not simply a department-focused response. It is a health care system response. Key purposes for the program: onsite case management and advocacy. I put this on here because I want you to look at the different between all case management, which is assessment, service planning, coordination, and advocacy. Our volunteer provide advocacy services after hours. The professional staff associated with Women Kind provide the ongoing contact to the client. And it's absolutely critical to have ongoing contact.

Now, we would not be providing services at Women Kind without what I call non-stop unrelenting training. For the health care provider to screen assess, say the right messages and refer the client to Women Kind that providers needs to be trained. They don't have the tools. I truly believe that the provider wants to provide appropriate services for victims of abuse. And we'll get to that in a minute. We do initial specialized training for all of the new staff in the hospitals. Regularly scheduled training for other providers and I think that the regularly scheduled training and the orientation of the nurses and the physicians has made all the difference in referrals to our program.

I should say that I have just left the Women Kind program late last Summer. It is still functioning. I think it's functioning well. What my job now is to do is to take the Women Kind program, the model that has been put together and help replicate that in other settings. And that's what I've been doing and it's been crazy.

Back in 1995 and '96, I got a call from Doctor Lynn Short at the Centers for Disease Control and Prevention on a Monday and told me on Friday we needed to get this proposal together to obtain funding so that CDC could evaluate the Women Kind program. First time an onsite program has, in fact, been evaluated. You could look at the population: provider, staff, volunteer advocates and victims, several

hospital sites, three Women Kind hospitals, two control hospitals. And the departments were ER, ICU and OB/GYN. Naturally you would like to have something like this be totally hospital or health care wide, but you certainly have to limit for evaluations purposes. This will give you an idea of what we looked at. There's a two year timeframe. Fifty one items surveyed for providers. Probably too long. By the time you schedule an hour training for providers and have them fill out a survey, pre and post training, you've already moved up to an hour and a half. And most providers - it's really hard to do that on a big lunch or during a lunch time or even a brief after hours training. Volunteers, baseline data, pre test and post test, we really have some outstanding data. Evaluations period itself was ten months. Now, if you look at the number of victims identified and referred to Women Kind, one thousand, seven hundred and nineteen victims referred in the Women Kind hospitals. Twenty seven victims identified and referred to training social workers in the control hospitals. The difference to me is astounding. We're talking about training, marketing, visibility and the presence, the immediate presence of an onsite referral. We also looked at chart reviews and found that ER providers at Women Kind hospitals documented in the medical records twice as frequently as ER providers at control hospitals. It is

simply what I describe as non-stop, unrelenting visibility marketing and training.

The formal training. In fact, even one to two hour training session was linked to a significant, positive impact on the provider's awareness and belief that they can do something about it. Providers really don't believe that they can make a difference. Why should I even ask her. She's not likely to acknowledge. They used to use the word admit, and so did I. Now I use the word acknowledge. But she's not going to do anything about it anyway. That is the understanding, obvious erroneous understanding, of a lot of providers. If they see what their role and responsibility is, they will screen, assess, document and refer. Increase providers that they even know how to do this. Increase screening of patients and it increased the documentation of domestic violence on these patients. The qualitative feedback from the providers. Women Kind professional staff and volunteers were seen as dependable, quick, competent, and respected. When Women Kind received the call twenty four hours a day there was an immediate response within thirty minutes of when that call came in. Someone was either in the hospital or came in from the outside to see that patient anywhere in the hospital setting, not including clinics early on I would say. Providers felt that Women Kind helped them improve their interactions, increasing their

sensitivity. What Women Kind did was give them the tools they needed to have to do their job. What we concluded was the availability of the onsite Women Kind program increased the provider's willingness to even address this issue and refer victims for services. Over all findings, the training increased the knowledge and understanding of the dynamics, the comfort level in addressing and it actually brought about an increase in assessment.

One of the other papers that you will have here is the training outline that was used. I put it all on one page. So I want you to look at it and understand that nowhere on this page does it say fix it. But it does, in fact, give some thoughts and tips on how to create a climate that will be conducive to a victim acknowledging and feeling safe. How to screen, intervene, document and refer. The key to this is the client services are provided in conjunction with provider training. You really can't do one without the other. You can't do the training if you don't have providers to train. Once you train you're going to have women identified. You have to have an onsite trusted location to refer them. We looked at the fact that providers need ongoing institutional support. There needs to be committees and forms for screening. Back in 1994 we put together the abuse prevention plan which screens for domestic abuse, child abuse and elder abuse. It made all

the difference. It was part of the system of patient admission and even if the patient did not immediately acknowledge, someone saw this and usually followed up on the fact that she might have been assessed or screened in January came back in March at which point she had thought about it and knew that this was a safe place and did, in fact, acknowledge. They knew the Women Kind staff and volunteers. The providers will be familiar with us. Made all the difference. Knowing it was a legitimate concern. And the prevalence data that I'm giving you will obviously document that. Self efficacy simply talks to the fact that they had the tools that they needed.

We will finish up with a brief look at the training that was provided. We looked at the climate, posters with tear off tabs in bathrooms. Posters everywhere. Some of my - I tried to permeate the entire health care system with knowledge and tips, instructions and tools on intervening for domestic violence. My not-so-nice friends used to say that I infiltrated the health care system. I thought it was a more professional approach than that. Screen and assess - marketing is huge. That is what this training does. That's what the posters do. That's what the pens do in our prenatal training for new moms and dads. They fill out a questionnaire, and one of the techniques used - all of the pens they used to fill out the questionnaire with are Women

Kind pens with the logo and the phone number. Now that is a very small indistinct message, but if anyone in that group knows that at some point he or she wants to access services, it's right there on the pen and all they have to do is either take the pen or write down the number. That you are constantly marketing the issue, the program, and the fact that we need an improved response. Screening and assessing is easy, I think. It doesn't have to take long. Injury or trauma - these injuries look like you might be injured by a personal injury. Is that happening to you? If it is, know that this hospital, this medical office is a safe place. The single greatest step that you can take is to institute routine screening of everybody every time. That may be difficult to do from a time standpoint, but the same way someone assesses, screens you for high cholesterol, diet, nutrition, do you ever get on a treadmill. That's done in annual physicals at this point. Because abuse and violence have become so violent in our cultural we've started to ask all of our patients about this issue. So that that patient knows that, you know, there's nothing particularly obvious about the fact that he or she is in an abusive relationship. It is simply a positive health care practice. That's the abuse prevention plan that we put together many years ago. It sounds strange to say get on a committee. Get on a committee that works on hospital and medical forms. It's

critical. It's one of the ways that you can kind of institutionalize the response. The role of the health care provider is here. Support, recognize it. Assess for escalating danger. Outline a safety plan. Schedule a follow up appointment. You aren't going to solve it all in this session. You aren't going to solve it at all. As health care providers it's not up to the provider. But it is up to all of us to screen and provide support.

Messages are simple. You all know these messages. You know, if this is happening to you are you're not at a point where you can talk about it, think about developing a safety plan. Think about keeping resource numbers, and for heaven's sake find one person that you can share what's happening to you. Most victims of abuse are isolated. That's one of the reasons that abuse is so effective. Find one person over six months who's safe and who gets it. To whom you can at least communicate when you need to. And maybe it's not happening to you. This ever happens to you or to someone you know, please know that our office is a safe place to talk about when you are ready. We once talked with a women, forty two year old women, happened to be in the ER. Every single one of us knew that she was a victim of a serious assault. She did not acknowledge. In fact, she denied, but she did say my sister is living in an abusive relationship. She agreed for me to come in and talk

to her to get information to help her sister. I don't care how she gets the information. Did she find out things that would be supportive and helpful for her that day?

Absolutely. I talked to her for two and a half hours. How do you measure success. Success is not necessarily getting out. Maybe. It's not our decision to make. Success is where is she in her process of change. What are the next small steps that victim/survivor wants to take? This what you're going to see. This is what's going on that's not visible. But when you think is isn't going to take any steps anyway, you see no visible signs of change. All of that's going on. And I think that internal change is far more important. Time is critical. You need to reach her while she is there. But if she doesn't acknowledge, don't think you've failed. I absolutely believe she still heard you. And she'll know where it's safe to come back. One of our long ago clients said this to me and I've never forgotten it. Sometimes making changes on the inside takes help from the outside. We are essentially the outside for a victim of domestic abuse. And are there any Packer fans in the room? Oh you guys. Kill. I was so tired of looking at blue slides that I made them green and gold. Thanks very much. (Applause.)

VANN: Hi. I'm Antonia Vann. I'm executive director as you heard from our ambassador of Asha Family Services. Asha

Family Services has been in operation since 1989 in the city of Milwaukee, Wisconsin. We formally incorporated in 1994 and have been in operation and expanding to multiple services which I'm going to leave sheets that will speak to how comprehensive our services had to go to. Because when you're working with victim population - as a matter of fact, how many of you are working or doing direct service provision to victims? Okay. How many of you are also looking at services or delivering services to a minority population? Okay. Asha Family Services is the state of Wisconsin's only state-funded domestic violence agency that is total specific to African American populations. And even saying that, still seventeen percent of our client base is not minority. We have several offices. We have community based services. We have an office in the district attorney's domestic violence unit. We staff the domestic violence unit as well as three domestic violence courts. We're also currently located at a W-2 site which is welfare to work. You're all familiar with the welfare to work system. And Wisconsin is one of the leading states that has been a forerunner in this welfare to work transition. At these sites we currently have about three thousand clients and the majority of these clients are considered the W-2-T. Who's familiar with W-2-T? Those are the individuals that their systems are trying to take from welfare to work. That

present what the most barriers to work. These are the domestic violence victims. These are those that have addictions to substances. These are those that have lower educational skills, lower work experience. So these are the ones that have the greater barriers to employment.

I'm going to talk to you about what works for Asha in the city of Milwaukee. One of the things when you're looking at your own communities, you're going to have to look to that minority population that it is that you are working with to come up with services specific to that. But as far as Asha Family Services, one of the things we initially had to - well not initially. We later found out just because I was African-America, for example, didn't mean that I could work with African-America populations. All of us can't work with all of us. And we needed to first understand the heterogeneity of the populations that we were dealing with. So we had to learn, including myself even though I'm a formerly battered wife, had to learn how to work with the population and get a clearer understanding. Which also meant school, university, studies, track. My areas of education initially started out in the social welfare department at UWM. But nothing I learned in the school of social welfare prepared me for what I was learning with working with battered women and working in a restraining order office doing domestic violence restraining

orders with four to six hundred people a month. And I had no preparation other than the on-hands and also having a mentor who turns out to be a pioneer. Many of you that were at the banquet last night heard Barb Hart talk about the three women that, along with herself, that were some of the pioneers. Well, my mentor turned out to be one of those forerunners, and she also taught graduate level courses and advocacy work at UWM. So I had a real good start not only that, I had God. So this was - I got pushed in a direction that I did not want to go. Because I certainly did not want to do this work. It was real difficult and nothing I'm going to tell you is easy. And for those of you that are doing the services, you know this work is not easy. Particularly working with this population.

We talk about what works. It's a combination of things that include a holistic approach for Asha Family Services in particular. And that takes a woman from where she's at - how she comes when she comes in the door. Susan spoke of some of that. Doing assessments on all the people that come in. Not using cookie cutter services - these are damaging. To use cookie cutter services there's going to have to be an evaluation, an assessment done on each individual and services need to be tailored specific to that individual. But also and in that it gives us a better understanding of who we're working with. What is the

heterodeneity - peace again. Looking at a number of different sub-groups. For many of us working with this population in the city of Milwaukee we had more of a non-conformist or deviant population. We have the partners of drug dealers. We had the partners of rollers, as they call themselves. The hustlers. We had individuals that have long criminal histories, multiple felonies. As a matter of fact, I'm glad to see Lynn here. Lynn is real familiar with the safe at home project that is going on in Milwaukee and Asha Family Services with two domestic violence programs is a part - has a small part in that project. And in the safe at home project, there's a piece to it that works with batterers. And in the batterer piece for Asha Family Services, one of the things that did come out was that we were seeing a population that was more violent. The batterers that we saw had multiple felony offenses. So, we had to look at what kind of individual that we need to run this program, work with this program. Our hope was that okay, we can get someone that is a reformed whatever and train and educate this individual to provide these services to that population, right? That sounds good, right? It doesn't happen like that all the time. Often times you're going to get someone because these fields are so new, because certain areas, if you're talking about doing culturally specific treatment methods, these things are

still real new. You still have Oliver Williams. You have Bob Hampton. You have other scholars, William Oliver - that are doing work in this area so in research - so that work is still out there. But in practice, it's not as wide spread as one would think it is. But there is work being done in the country and then - even like Asha, there are places carrying on this work in the country that don't necessarily get the real visibility, discontinue the work. So one of the things we have to look at is this target population. Who it is that you're working with. Understanding the background, the community, the whole dynamic. Looking at a deviant population - this group of individuals who nobody likes - no cultural group likes - is responsible for ninety nine point nine percent of much of the crime in the central city. They have their own set of rules. They have their own set of goals. But they do have some things that the dominant society has in place. They have their own rules as I said and for infractions against the group, sanctions are swift and they're fact and they're hard. So using - within this same structure to deliver services to this population really needs to be specific to that population. So even with an instance with taking my two children. My daughter is twenty seven. She's a flight attendant. Just got married. College graduate. And she is very different than my twenty four year old who is also a college student. He's

married. But if you look at these two - put these two kids together and for one go into my daughter's apartment. Nothing in there would tell her that there were black child lived in this house. But you go to my boy's house, you're going to see his decor, his furnishings, his artwork, his books, his music. All of it will say that this is a black child that lives in this household. But now these two children came out of the same house. They have the same information, particularly about their legacy, their history in this country, all the richness that their legacy or history bring to this country because their mamma gave it to them. I gave it to them. So they also made their choices about how they were going to live their lives. One of the things I did not do was preach hatred, racism, and I didn't tolerate these kinds of things. They were exposed to multiple cultures with love to celebrate these different cultural groups. So those teachings were not there which is why you can take two children out of the same household and one who has made other choices to live her life a certain kind of way or have a certain kind of group of friends. But then you'll have another child that would be very different. So looking at these two populations and service delivery for these two. My daughter would do real well in traditional services. She would do very well. But now my son - but also for another compounded reason. For one, he's a black

male. So another example is where as my daughter might have been - my daughter has never been arrested, pulled over by the police. Where my son, who is a college student, has been probably pulled over by the police five times just for the fact that he is an African-American male. So there experiences are real different. So again it's real important to look at the population and understand that group that it is that you're working with.

A major help is to understand and appreciate that the help seeking behavior of African-American women are different then the norm. Yet in some cases, it is still the same as women from other cultural groups. Dealing with her where she is at includes her emotional state, her spiritual state, and her physical state. And providers need to address first what she defines as being important to her. And often times that is not going to be the violence. She has learned to live with that. She's become anesthetized to that, particularly if she comes from a community where there is high crime. Usually the night brought about a number of gun fire in the street. Hollering, yelling, dogs fighting, horns blowing. You know, I hate that. I wish they blew up all of those just because - but all of this stuff within the community. But you also need to understand that while mom is there in this community, so are these little bitty people that have to go to school the next day. These are the

children. So this whole other generation is getting prepared to take on some stuff. They're being taught some things.

Often times her most concern is often times housing. Where am I going to go? Where do I have to live? I don't have the money to take my children out of this community. I don't have the money to take them out of the projects. So there's going to be some other kinds of issues that will have to be dealt with. Housing, mental health, employment, underemployment and I was just real pleased that Susan had mentioned a piece about mental health issues. Often times these women present with multiple kinds of issues that don't necessarily look like mental health disorders. Often times her anger, which is often times profound sadness but it doesn't look like that. So her behavior gets mis-diagnosed. And we'll talk about that a little bit later. Furnishing, clothing for the children, emergency items such as food. I can't tell you the number of times that women who are partners with drug addicts have gone home and their houses have been cleaned out. _____ electronic equipment, even food taken out of the refrigerator and sold. So there is a number of kinds of emergency things that might need to happen before you can even get her in the mind set of doing something towards working towards the violence and her safety.

Traditional barriers to help must be eliminated or lessened. That is access to services, women and other people of color like services located within their own community. Their environment must be welcoming and comfortable and familiar and the primary people need to look like her and share in ancestry with her. Integrated comprehensive services at the same agency is also a preference. Asha Family Services initially started out doing just victim services. Now we have a multitude of services. We have battered treatment services. We have children's services for kids. We have an outpatient mental health and substance abuse treatment clinic. We have programming specific to children. WE have programming specific to sexual assault survivors that are adolescents and sexual assault perpetrators. We have family services that are specific to an entire unit. So we've had to expand based on the needs of the populations that we're working with.

Transportation to services has been a biggie. Transportation, child care. One of the things Asha provides is onsite child care and transportation to our service delivery. Spirituality is very important to this target population. Even if the male population dies during the batterers treatment services have had much success with helping to facilitate a connection with a spiritual being

higher than these individuals connecting with someone to assist with some kind of process that will look at behaviors and helping making life changes. Advocacy and accompaniment to learning to access services. It is so difficult to give someone a card and say, "Go over there to this, and they'll get you that." That often times doesn't work. Our staff provide accompaniment to services and give them education on that services. For example, the DAL(?) office location. If someone's going over for a restraining order, they accompany them to the restraining order. They educate them on the system. What's going to happen. And another key piece to that is once that client leaves or once they've taken them to the restraining order office and they've taken them to the Sheriff's department, they've taken them to the policy department to drop off notification of their restraining order, and then they take them home. Then the other piece to that is they do follow up the very next day. So follow up with these people is real critical and assisting on couple of different things. Building trust and also to offer and lend support and empathy to whoever it is you're working with.

Information ongoing. Information and education is real critical. I can't tell you the number of times we've gone into a courtroom - I'm standing there with a woman who's been victimized by her husband or victimized by her

partner and once we come out of the courtroom you ask her, "Do you understand what happened?" and she'll tell you no. They don't understand what happened. So you're going to have to tell them ten times if that's what it takes. Remind them. Call them the next day. I'll pick you up for court or for the next hearing. So you're looking at doing a lot more intense kinds of things. Treat it with respect and the highest regard and importance. That is so critical when these people come into the door. I'm saying these people, but I'm talking about me. Because when I'm looking at them, that's one of the things that put me on this track. Every time I look in the mirror, I'm looking at myself.

Child care and transportation we talked about. The other piece is concrete examples of how to do something or to get somewhere. Tell them exactly where they need to go. Sit there and make the calls for them. We work a lot with probation and parole agents, probation and parole agents or anyone referring someone for services. An appointment is immediately made at that time. Transportation, home visits - our case managers are care coordinators. They're actually case managers. They'll make home visits. They do the transportation. They provide the empathy and support. They'll do the assessments within the homes of these people as well.

Strong awareness and education campaigns within this

target community is also very important. Susan was talking about some of the places where they put some of the literature and the tear offs. They also need to go into the hair salons. They need to go into the nail salons. They need to go into the barber shops, and the liquor stores, and the corner store. They also need to be put on the billboards in these communities. Access to materials, just like the pens or whatever. Even small laminated cards people can put in their pockets. But also this material needs to be broken down in such a way that it's easy for them to understand and easy for them to read. In this three thousand that I was telling you about, the majority of them have low reading skills. There is a high literacy need in the city of Milwaukee. So that piece is also critical.

I just wanted to kind of touch more, just say a couple more things on the mental health piece. Often times people come in and they're really angry, they're really upset. You have to take another approach to working with these individuals. And that is you can look them in the face, but also take on a posture that you do believe them. That I'm not just another person - you know, I've had women come in hollering and cussing and one time I was the only black staff at task force and they tell me would you talk to her. And the women come in and she's hollering and screaming and cussing, you know, you better get him before I kill him and

this and that. And I tell them I hear you.

(End of Side A. Turning tape over to Side B.)

Q: I have a question with your services. I work at a shelter in North Carolina and with your services it sounds like there is a lot of hand holding. It sounds like everything you do is very supportive and we try and do the same things, but we focus so much more on self-help and empowerment. I'm wondering what your thought is now that some of the focus on empowerment versus the hand holding and what you're saying that you're doing -

A: They're one and the same. Now there's a period of time when there's a crisis. And while people are going through that crisis, we assist them through their crisis. We're going to show them how we do this. But often times when they come back and ask a question or it's some kind of dependency, for example, has come into play. Well the care coordinators are very skilled _____ or remember how we went there. These kinds of things. So it is one and the same and the difference is _____. Because there is. And it's because of the number of things that happen, the cause of the isolation of a minority population. _____ There's some things that _____ why she won't do certain things. And that needs to come into play. _____ additional support. Because often times while we're there making her do that and

then she comes out of the courtroom after she's done, you say, "Girl, you did it." And she says, "Yes, I did." But they're one and the same. One has more of a time limit on it. This is a little longer.

SEAVER: Okay. I'm Carol Seaver. I work with older battered women in Milwaukee, Wisconsin, and I love the question that was asked about well how much do you really help and what's empowering. Because it's a perfect _____ into my population of older women and also I'm trying to be more helpful to all women who are disabled because I think one of the speakers this lunch time was so eloquent on the idea of let's stop talking about marginalized women as special needs. If you're being violated, you have a basic need to safety. And I though, yes. We're not talking about special add-on populations. Let's make the margin the center. And I think you're question is excellent about when do you do something for someone and when do you have them do it themselves. And I think this is a crucial question that we always face. I have four children, and I think when you're a parent you're always struggling with that also. When do you need to do it and when can they do it? And I think what Antonia was saying is you sort of weigh it, but definitely with the idea if the person can do it, then let's let them get there and get this sense that they really did do it themselves. I'll give an example of that because to

me it was so inspiring. A woman whose son had almost killed her was terrified. She had gone through so much mental anguish. She had gone in and out of mental institutions actually because of his abuse of her. He was in and out of jails. And would you believe it or not, when they wanted to finally get him out of jail, they called her as a place to put him. So, anyway, as we are getting ready - well, what's interesting is that her son was so sharp. He was like a jailhouse lawyer. He was really intelligent and he had organized some of the other folks. And so when it came up for his release she was just laughed out of court as far as the fact that he had raped a niece and they were all just terrified of him. But somehow he was able to use the court system in such a way that he got out. And the only thing that we had was this restraining order. And what I was worried about, and I talked to one of our judges in Milwaukee who's an expert on testimony by abused children. I said, "How can I get this woman who has a panic anxiety disorder almost over this to do this? What do you say for that?" And Judge Shipson(?) did talk to me about it and we just sort of felt, well let's see. Let's see what by encouraging her - so what happened is as I picked her up in the morning and was driving to the courthouse I just said, "Well, why don't you just tell me the way you were going to do it later. Just tell me how you're going to describe it

to the courtroom." And she did it. She was able to do it. And this was in the car on the freeway in the morning. It wasn't the perfect situation. But what seemed to help was rehearsing it. Because when we got in the courtroom and the judge asked her, "So what is going on?" She could say it because she had already just said it a half an hour before. And I didn't really plan it like that, but it just worked out really well, and I would suggest if you have someone who is that frightened, that it's a wonderful way of helping people to do something that neither of you thinks that they can do it. This particular courtroom incident, by the way, it so happened that the judge the day before had been physically attacked by someone in his courtroom. So the whole courtroom was just very tense. And when I came back to the shelter that morning, and I said, "Gee, everyone was so tense in the courtroom, and they told us that they'd give us an escort to the parking lot. What was that about?" They said, "Didn't you see the paper this morning?" And so there's judges that are sometimes in danger too. But what I wanted to say in the little time that I have here, because I don't want to use all the time. I want to make sure that everyone has a chance here. Is that of the three hundred older women, and what I mean by older, is women over fifty. Of the three hundred women I've worked with, about forty percent of them have gotten free of abuse. And that doesn't

mean totally free of their partner. They might be in some kind of contact or other, but basically there is some kind of freedom and growth there.

I do case management. I have a support group. And this last Thursday - we meet on Thursdays at the shelter for two hours. It's a drop in group. I'd strongly recommend if you're going to do any kind of service for a marginalized group, is start with the support group. Because the women learn more and get more from each other than they'd ever get for anybody else. I'm learning all the time. And I said, "Okay, so what should tell them in Chicago?" And they said, "Tell people to hang in there, of course." But one of the biggest things was just to make sure that if the situation is tough - if you see that your husband who you thought was this prince charming turns out to be a batterer, try and leave before your own body is falling apart. Because that's one of the things that happens unfortunately. Those of us who get a little up there, our bodies are not quite the same. They don't bounce back as easily. And I was going to have shown a video, but I think we need the time for other testimony here today.

But certainly what happens for older women that's different is that some of the women in the group, for instance, one woman who did stay with her husband until he died. He was his caregiver for about twenty years. And he

was abusive to her that entire time. Throwing his cane at her. Just about not letting her out of his sight. And verbally abusive from morning til night. She had several heart attacks. I'm glad she's still with us. And one of the things that she did which was interesting, she sort of crocheted her way out. It's interesting because one of the clichés about an older women, when we first started support group, they said, "Well people won't want to talk. These old ladies aren't going to want to talk. They'll just want to knit and crochet." That's a stereotype. But in this case, the women - let's call her Mary - crocheting was her lifeline because she said what happened is when her husband would start yelling at her someday, she'd be busy and say, "Hold it, I'm counting." And not only that but because in her regular job she would give over her money. Her crocheting was also this little pocket change that she developed. She would sell it. Well, this pocket change bought a freezer, the rocker, the this. Her whole place was furnished with the earnings from her crocheting. And she still does these magnificent things and it's really beautiful to see that people can survive even in the tightest spots.

One of the things about when you're older and faced with the dependency of a frail husband or the dependency of an alcoholic, unemployed son. It's not at all to say, "Oh,

get rid of this guy." It's not at all. Their dependency is what puts you at risk. And the morality of the women might be, "I'm going to stay no matter what." And I've had women say, "Carol, if this was your son, would you put him" - and I can't honestly say, "Oh, yeah, I'd just put him out there." Sometimes it works that putting the person out will actually work. A couple that did that with their son - he's back in school now, and he's more on track and it did really work that way. But sometimes in the case of one of the women in the group where she was abandoned by her husband earlier when this very same child was two years old. She's so afraid of being alone that she'd rather see him then - so what I love, though, about learning from the older women that I work with is that there's a hundred thousand different ways to handle abuse. There is no one size fits all. So I think one of the things I'd like to see is more communication between older women who have been through a lot and younger women. And we're still going to try and do some of that at the shelter. I thank you.

FELIPE PEREZ: Good afternoon. My name is Felipe Perez. I work in Atlanta with the Latino Family Service Program. I'm a facilitator in Latino Batterers Intervention Program. I was very excited when I was at lunch because I hear Mrs. Donna Shalala said that we had to work with the whole members of the family. I am very proud of the program

because it is what we are doing already. To give you a little bit of history of the program is what I'm going to talk about - the history of the Latino Family Service Program.

JUANA: Okay. The Latino Family At Risk Program began in 1990. Sister _____ was working with the Latino community in the mobile clinics is when she saw women come into the clinics and saw them with real serious and black eyes. And the women began to trust her and considered her that they have been battered by their partners. Then Julia and Sister _____ started a support group for women. Later on, at first some women come to the group, but little by little the group started to growing. Then when we have the support group, the women started to bring their children to the group because we can not leave our children by themselves so we need to bring them. It's when we saw that how the children was affecting the violence in the homes because they started to fight each others. That's when we saw the need to have a location for the children too. Three years ago, the women started to ask us, "Why, if you say that the men are the problem, why you don't start working with the men because" - (Laughter). And then is when we saw the need and we started to think about doing something. And in 1995, we invited Felipe to begin a group, intervention group, for men. And in 1999, they got

_____. Felipe's going to explain a little bit more about the importance _____ for us.

FELIPE PEREZ: Thank you Juana. Before I talk about the importance that _____ is to the program, I want to explain a little bit about how the program is structured. If we want to work with _____ the community and the agencies around us working with us is what we're doing so far. But let me tell you as far as Latino Family Service has three components. We have women's program, children's program, and men's program. As Juana said the _____ Mission is very important for our program because that's where we have the groups in different settings. Mercy Mobile Health Care is one of the programs who are giving money and support for the women's and children's program. And _____ Mission became very important for us because they are taking care of the men's program now.

The other thing is the relationship that we have with the old agencies. The very important thing is tapestry is refugee and immigrant coalition against domestic violence. And we are part of this coalition in Atlanta, and we have different agencies that serve minorities. The other important thing is that we work in coalition with the core system. Is very important to work with the core system in this issue especially in the intervention group with men. We have a coalition too with Atlanta legal aid. And

International Women House is one other important part of our community because this International Women House serve also refugee and immigrant women, battered women. So it's a very important part of our program. A _____ issues and services, they provide some services like they find jobs for people looking and some other services that they provide. Legal services they provide also. And the rape crisis centers. We have coalition of the women's group with the rape crisis center. So as you see, the community and agencies around us are very important part of our program.

Now, Juana is going to explain a little bit how is the women's program. I hope this time I did it right.

JUANA PEREZ: Okay. In the women's support group, we have a weekly support group with _____ two levels. The very important part is the location. The location we give to the woman. This location was asking for the women who come to the group. And some of the topics are domestic violence, dynamics, and the cycle of violence, safety issues, self esteem, sexuality, health issues, legal issues, STDs and HIV, _____, child development, substance abuse awareness. Other topics _____ by group members. Crafts, pot lucks, phone contact, home visits, _____, access to shelters, legal services, volunteer lawyers, limited _____, and referred to community services. This was a women's group, so we are going to

access the programs. The children's program. In our program, we have a lot of children because each woman bring more than three children, so thus we have a need to have the groups for the children. The first group we have is the little tiny ones until three years old. For these children we give them like babysitter because they are so tiny. But it is very important because I am very pleased with the volunteers because they give a special time for these children. I want to tell more about it, but I don't have time and I need to explain the _____.

The other group is the group for children four age to seven years old; and eight to eleven; and twelve and up. We have a location for these groups and this is family, _____ single, relationships, violence, safety plans, sexuality, dreams and goals to _____.

FELIPE PEREZ: I think one of the important things that _____ is that sometimes women bring the children _____ in the afternoon it starts at seven, but some of the children have brought the homework so when they come to the group the volunteers and some staff members help them to do their homework. And it's very important to the children to keep up with their homework. The other thing is the connection that we or the support that we give to the parents with the schools. Sometimes both parents doesn't speak English, so we have the coordinator of this children's

group go to the schools if any children have any problem. So we try to cooperate with the schools, and we ask them what is the problem? How we can cooperate with you? And then we have an excellent results in that. WE always - and the parents are pleased to bring the children to the school and end the problem.

The other issue is that we talk about _____ component things like the celebration that we do in our country, our flags and all these issues that are very important to our children to learn our traditions. We have services, individual and family, and these are only in special cases because we don't have too many resources, but the individual help only for mother and children.

The other activities are art, dance, music, crafts and story telling that the children come to the group and they do all these things in the group. One important thing is the staff and volunteers model respect so if we model respect between us, so the children are seeing that and we model that to the groups and we're going to explain that.

I'm going to explain a little bit about the men's intervention group. We have the program. It's for twenty four weeks. I hope one day we can have like in San Francisco, fifty two weeks. Right now Georgia law I think they only permit twenty four weeks. The men's group - we have two levels. The first level start with the men - the

men who start coming until the fourteen weeks. In these fourteen weeks we do basic education about violence and domestic violence. And it is a very structured setting. In the first session, the man is going to come because it's mandated and he's going to be very reluctant to come. And sometimes they did what they want, but in this case, we have to _____ the way it is. So they don't have no choice. The other thing we do is that we do physical exercises where the man identifies themselves and identifies the violence. And we talk about two emotions. It's very important in our cultural because usually men - we are not taught to recognize our emotional state, our emotions. So we talk of this every week on this topic. WE have the second level of the batterers group, and in the second level there has to be some rules that the men can go to the second level. The first is that he's not supposed to be violent physically for fourteen weeks. The other thing is that he has to learn the material that we explain every week. We don't have any writing or reading assignment. It's only oral. We do the group orally. All members ask the new members - the men who want to go to the second level, they ask them about the problem. And if they decide that he doesn't know the material, they're going to tell him and support him to stay a few more weeks in the first level until he's ready to go to the second level. So, this is how

we work. In the second level too, when the men go to the second level, they focus more on the verbal, emotional and sexual abuse. So the model that we have for us it was modeled after _____ that Antonia Ramirez was one of the trainers on this. And it was men talking violence in Atlanta. So the model was tailored to our Latino necessities in Atlanta. So we take some of the things that the _____ have and then we tailored it to our needs in Atlanta. The other thing is that our program uses cultural traditions, _____, and values. And very important thing in Spanish this is the language that is very important thing for the Latino men because it's a Spanish speaking group. There are very simple and clear rules. The other important thing is one of the programs that we have in the Latino communities is substance abuse of alcohol - it's very high, the incidents of alcohol in the Latino community. So the first hour of the program, for the men's program, is education and information about alcohol and drugs. And the second hour and a half is domestic violence. So we have these two components in the men's group. In the alcohol and drugs group, the men _____ the substance abuse and violence. And they note that they are two different problems. One is the violence. One is the alcohol problem. And they know that one is not a cause of the other one. So when we have a man who has an alcohol problem, very deep

alcohol problem, we send him to an AA program in Spanish.

The other very important issues that we talk about is that as you can see the women's program, they have a parenting and STDs and HIV education. And we can all just learn the men with all these issues because sometimes - many times the man has another relations outside the house and this is very important for them to know about it. We have this two times a year because the program is six months. So new members can have the opportunity to know this.

And one other thing is fifty hours community work instead of fee. Our program is free. We don't charge any money. However, as payment of the community, the man has to do fifty hours of community work to _____ Mission. They have to clean, they have to paint, whatever the Mission needs, they have to do it. Let me tell you what. Sometime the man wants to paint, and they don't want - (Laughter.) or send another man to do their job, but they don't want to do it. They have to do it anyway. Some of the men say it is my wife or children can help to the community. I will say, "Sorry, but you'll have to do it." So it is very important. We give some back to the community. Because the community is affected too for the violence.

Q: Are they coming to this group voluntarily?

PEREZ: This is what - we're not talking - the majority of the men are accommodated. But we have men who came to the

program voluntary. And most of the men they stay over the limit - they end in twenty four weeks, but most of the men, they stay over the twenty four weeks because some of the reasons that we want to say here.

JUANA PEREZ: Okay we are going to list the statistics. Approximately ninety nine percent of our clients are from Mexico, immigrants from Mexico. Ninety nine percent are immigrants. About seventy percent are Mexican. And the other one are Central American and Caribbean and South America. This is the numbers we have for the last few years is '95 we have four hundred and two participants. 1996 four hundred eighty four. '97, four hundred and seven. '98 five hundred ninety six, and 1999 four hundred thirty eight in the first six months. So, our program is growing. Numbers - Of families, in 1998 two hundred and eighty seven. 1999, two hundred and five in the first six months. Over ninety five percent of accommodated men finished the program.

Q: How do you do that? Really.

FELIPE PEREZ: I think one of the keys of the program is that we're working with the whole family. Sometimes -

Q: (?)

FELIPE PEREZ: The other point is that only three men have to have been sent back to the courts for a new instance of physical violence. Yes.

We're going to talk about some results. The others

programs are evaluated and one of the - men stopped their physical violence in the second and third week when they came to the program. The verbal and emotional abuse is more difficult to eliminate and sometimes increase once the men stopped the physical violence, the emotional and verbal increase. So this is why in the second level we were more open with those issues. And the amazing thing too is once the men enter into the program, many of them they stop using alcohol. We have a man who was using drugs and alcohol for about the whole life and when he came to the program, he keeps clean for six months and he's troubling with that, but he's keep doing that, you know. The other thing is that men increase awareness of that and sexual abuse, sexual violence in the partnership. And one other thing is that men and women start defining their roles in the family. Other important thing that women ask and men ask too is about parenting issues. They become more interested in parenting issues. Many of the families still come into the program on a voluntary basis. One of the effects of working with the whole families that the children improve their behaviors and attitudes and do better in school too. So this is one of the things that they've found in the evaluation and experience working with the whole family. The most success with the families is when the whole family come to the program. So the children get benefit. Women get support

and education too.

JUANA PEREZ: Okay. Why do we do it this way? _____
very traditional. Most of them are the first generation to come to the United States. Family most important in their life. Most women decided to stay in the relationship. Many of them depend on their partner for transportation. Working with men and children helps women use services longer. Adds to the safety by knowing what happens with entire family. Our goal is not to make up or stay together or break up. The decision is entirely up to the woman however long it takes - support for her decision.

FELIPE PEREZ: The last thing we want to say is that the Latino Family Services is where women and children seek support and education regarding the violence. They have experience in the manner and language familiar to them. At the same time, Latino batterers are held accountable for the violence by many parts of their community while being supported to change their violent behaviors and attitudes in an atmosphere of respect. So this is basically what we do offer in the program. Thank you. (Applause.)
(Group discussion. People all talking at once.)