MIECHV Advisory board meeting
March 12, 2015 2:00 – 4:00 PM South Campus

Board members in attendance: Linda Grossman (Baltimore County Dept of Health), Sonya Satterlund (Dept of Family Services; HFA), Kimberli Hammond (Healthy Families), Sharon Rumbar (Baltimore City Health Dept), Sandra Haskett (Baltimore City Health Dept, NFP), Erin Clarke (From Mary's team. Sitting in)
On phone: Lyn Kosanovich (Preventing Child Abuse America), Melissa McElroy (EHS), Akima Copper (EHS), Dawn Scher (Healthy Families)
From UMBC: Carlo DiClemente, Dave Schultz, Robin Barry, Charissa Cheah, Rebecca Schacht, June Sutherland, Lisa Shanty, Shelby Jones

- Welcome and introductions from Carlo and Dave

Focus group discussion

- **Feedback on training surrounding substance abuse, domestic violence, and mental health.**
  - The Health Department uses two models (NFP and HFA; both models have RNs) and collaborate Johns Hopkins School of Nursing **(***Phase 2 around Domestic Violence with Phyllis Sharps*).
  - Baltimore City HFA has a training mandate (3, 6, and 12 month training requirement with a domestic violence identification and mental health screening piece). They also partner with the Health Department and Dr. Sharps with DOVE training (domestic violence). All staff members are trained on Mothers and Babies curriculum, can do prenatal risk assessment, and can support parents who are likely to be depressed.
  - Caroline County partners with the mental health department. The director, Mike Campbell comes in once a month to meet with home visitors and goes over different mental health strategies for home visitors to use (case reviews).
  - Washington County contracts with nurses from local hospitals. They talk more about postpartum depression. All of Head Start participates in Mental Health first aid training (*overview of mental health, what to look for*), but no specific strategies for how to deal with severe mental health.
  - The Regional Perinatal Advisory Group substance abuse and pregnancy toolkit might be a helpful resource to include. It was created by a collaborative of health providers and includes accurate/current information about substance abuse effects (how to screen, how to proceed with referrals).
  - Important to have a nurse embedded in the program.
  - HFA trainings have online modules, which includes both mental health and domestic violence. All HFA staff members are required to complete modules within 3,6,12 months of hire. Updates are currently being made to the domestic violence module and a webinar on postpartum depression is also being developed. All HFA sites are mandated to do depression screening with new moms prenatally and at least once after birth.

- **Feedback on the amount of trainings offered on developing healthy adult relationships (and is there a need for training on this?)**
  - A lot of the curricula address developing healthy adult relationships in different sections (e.g. making dad part of prenatal process, Partners for Healthy Babies, Finding the Goal Within).
  - Funding through Centers for Urban Families allowed for a curriculum add-on that pushes for partner-partner interactions and positive co-parenting, whether romantically attached or not.

- Have not received adequate training on developing healthy relationships. Tap into local resources from the health department and crisis shelter to provide more training.
- It would be beneficial to have more training on this topic, especially with young mothers and immigrant mothers.

- **Feedback on program's position regarding co-sleeping/discipline/family planning/other parenting issues**
  - Healthy Families National Office does not encourage spanking. They do encourage home visitors to have conversations with parents to understand cultural expectations/norms and be able to explain what spanking does to a child.
  - HFA does not have a strong position on family planning. The expectation is that the home visitors will be open to talking about any of the options of birth control (*provide options but don't push any one method*), and be accepting of what the family wants.
  - Encourage home visitors to put aside personal opinions and use the research behind spanking and some objective feedback.
  - Talking to women about pregnancy spacing is a good idea but cannot suggest any specific form of birth control.
  - The home visitors ask when mothers are planning to have more children. Co-sleeping comes up culturally. They encourage safe sleeping but also share cultural studies from Zero to Three and then address safety concerns without explicitly telling them not to co- sleep.
  - Most programs are strongly urging women to think ahead about what they want their lives to look like, so the topic of family planning comes up naturally. It's not a confrontation but instead is part of goal setting.
- **Feedback and discussion on the content of cultural competence training**
  - Three, six and nine month trainings have cultural competence embedded. Basic training covers respect of different cultures and how to ask questions, being a ready learner for home visits and refraining from making assumptions. In-house trainings and collaborative trainings are done with Health Department and Family League. (*These trainings go beyond ethnicity/race and cover topics such as substance abuse culture, open air drug marketing, teenager as head of household, teen parenting, and generational differences within the family).*
  - In Baltimore city, this is primarily covered in biweekly supervision meetings and through collaboration with Baltimore Medical Systems.
  - Addressed in supervision on an individual basis. Training is more about cultural differences than cultural competence. Populations that we serve are not that diverse in some regions.

Adult learning principles overview

- **Discussion/feedback on training experiences found to be helpful-- Best practices**
  - Most staff typically hates role plays. Use the word "practicing" instead of "role plays."
  - Practice using forms (for interviewing process) to avoid stumbling over words.
  - Use stories.
  - Plan ahead of time, ask people to submit 3 questions they hope will get answered in the training. This also encourages people to do some prep/ research ahead of time.
  - Make sessions interactive and keep lecturing at a minimum.
  - Encourage the concept of co-instruction:
    - Have home visitors share strategies for how to handle certain situations. It's also empowering for HVs to be able to share successes.

MI outline discussion

- Several were looking forward to the demonstration at HV conference; no general comments about the outline

General module discussion

- **How could we structure these 6 modules to be manageable for you? How much time is feasible for additional trainings?**
  - Conduct one substantial session on a given topic, then schedule 2 follow up sessions at either 1 or 2 month intervals to allow time for home visitors to acquire examples they can share. It's a commitment to use what they learned and talk it through with the experts. Home visitors could also provide feedback on how to make training better for future people.
- **When in the HV's career would you encourage the certificate?**
  - Certainly not in the first year or not even 6-9 months after because people get burned out from training. Maybe 24-30 months because this is when HVs wander away from training.
  - Consider pairing two topics together (*communications/substance abuse, Culture/healthy partner relationships, and Parenting/mental health*).
  - This training strengthens core competencies (*this can build skill while you're in the field learning*), so it may be best to have these trainings earlier because most burnout happens within the first 2 years. Maybe 6 months out is the best time to do this so they can integrate these skills.
  - Supervisors should be integrated in training modules, so they have an opportunity to partner with home visitors and have discussions about training.
- **Should we coach the HVs or coach the supervisors to coach the HVs?**
  - Often, supervisors attend trainings with staff. It's important for supervisors to know what their staff is learning.
  - It's important for them to learn together. It might be a burden to both coach and supervise. Better to just train them together initially, so they can reflect on the training together.
- **Do you use tapes for supervision?**
  - In NFP, no. Four months after the HV starts seeing families, supervisor shadows a visit. Supervisor completes a form/questionnaire about how the home visitor has integrated the different domains/topics into the visit.
  - Shadow visits are done at HFA.
- **What is going to be the focus for professional staff vs unlicensed staff? E.g. NFP are all nurses.**
  - Considering CEU credits
  - Nurses are not required to have CEUs in Maryland, but social workers are.
- **Additional Feedback:**
  - The training center should not be worried about double training. Do training after they've had some experience, after they've struggled and recognize that they need training. Six months to a year in, they'll realize how hard the job is. That will be incentive enough to seek out additional training.

- **Conclusion:**
  - Potentially another meeting in early summer to discuss the other training modules and get feedback on how to best balance content and practice.