
MODELS FOR PRACTICE

FOCUS AREA: INJURY AND VIOLENCE PREVENTION

Program Name: Rural Response to Intimate Partner Violence

Location: Franklin and Washington Counties, Maine

Problem Addressed: Injury and Violence Prevention

Healthy People 2010 Objective: 15

Web Address: www.mepca.org

SNAPSHOT

In the 1990s, Intimate Partner Violence (IPV) was identified by the Maine Primary Care Association (MPCA) as a critical public health concern because of its pervasiveness and its impact on the physical and mental health of victims and their children. The problem is particularly insidious and resistant to intervention in the rural areas where most of MPCA's member community health centers are located. In 1996, with funding from Centers for Disease Control (CDC), MPCA initiated a six-year pilot project at four sites. The project emphasized changing clinical practices and building community coalitions, with the goal of increasing awareness of and commitment to change on the part of community members and clinicians to intimate partner violence. Incidence rates for such a complex behavior take decades to change, but MPCA has measured significant changes in community awareness and attitudes, and in clinical practices, over the course of the project.

THE MODEL

Blueprint: Rural Response to Intimate Partner Violence is a six-year pilot project involving four program sites and one comparison site, all located at community health centers in rural Maine. These remote areas are economically distressed, and in 1996, nearly a quarter of the population lived below the federal poverty level with an unemployment rate 40 percent higher than the state average. These conditions, combined with the lack of access to social services, make addressing IPV particularly challenging in rural areas.

The Maine Primary Care Association has been instrumental in managing this program, with funding via two three-year grants from CDC. At each program site, a community coalition was formed, with staff support provided by the local health center through a subgrant from MPCA. Project activities, aimed at increasing awareness of IPV among clinicians, patients, and the community at-large, were carried out simultaneously at the local and state level. At the local level, each of the four program sites began their activities in a similar way following the initially proposed plan; however,

over time, the programs diverged as their coalitions matured and as differing global circumstances and perspectives became increasingly influential.

The primary goal of the program is to develop a coordinated community response to IPV through the use of community coalitions that will develop and implement primary prevention programs, empower and support programs, and provide training and education about IPV. MPCA provides the structure to support these coalitions, including development of prevention and training programs, as well as program facilitation and evaluation.

The four coalitions vary in size (from 13 to 30 participants) and in the scope of their activities, but overall, the coalitions include the following entities: law enforcement officers and officers of the courts, educators, counselors, health care providers (clinical and administrative), domestic violence victim service providers, substance abuse agencies, batterers intervention projects, clergy, business owners, government employees, artists, students, victims/survivors and witnesses of abuse, and other interested community members.

Making a Difference: Expanded community awareness was the program's major goal and impact. Prior to the inception of the project, family violence was not openly discussed in the home, community, or clinician's office. By the end of the project, active screening was a part of all health center protocols. Local businesses, schools, and media outlets were all partners in distributing information and addressing the issue of community values. Project impact was assessed through administration of the following instruments: anonymous patient surveys, clinician surveys, coalition member surveys, and medical record audits.

Anonymous patient surveys were collected as a means to inform clinicians about the incidence of abuse experienced in their practices. Compiled results revealed that 18-25 year olds reported the highest incidences of abuse within the previous 12 months (24 percent) followed by 26-35 year olds (22 percent), although there was wide variation among the individual program sites. Nationally, lifetime experience of domestic violence by women is generally estimated at 31 percent. Combined data from the four Maine health centers, however, revealed an average lifetime experience of about 50 percent, ranging from 55 percent for ages 18-50 to 47 percent for ages 51-65 and 22 percent for those 66 years old and over.

A key goal of the project was to increase the rate of proactive clinician engagement with patients on the issue. Patient surveys at project sites reflected an increase in clinician inquiries about violence. Patient-reported inquiry rates increased, on average, from 23 percent in 1998 to 35 percent in 2002. Inquiry rates at the control site remained at 23 percent over that same period. These baseline data are similar to those from national surveys (typically reported as showing that 80 percent of all women have never been asked about family violence by a health care provider).

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The clinician survey conducted in 2000 and 2002 showed that 60 percent of the clinicians said they “almost always” or “often” asked about IPV at annual exams/regular checkups, and 73 percent said they “almost always” or “often” asked about IPV if the patient presented with an injury. The patient survey responses cited above confirm that clinician inquiries did increase. Most clinicians reported changes in their clinical behavior as a result of this project, especially increases in awareness and assertiveness in asking patients about the issue, some relating these changes directly to the project's educational activities. The surveys also reflect increasing awareness of local community resources, confidence in referring patients to those resources, and reduced obstacles in assisting women who have experienced abuse.

Findings from the coalition member survey to date show that the members are satisfied with the work of the coalition; nearly all respondents are able to identify at least one major accomplishment of their coalition in the past year, generally related to activities carried out to increase community awareness. Nearly every respondent felt that the coalition had improved coordination of IPV services in their community.

Finally, audits of patient records show an increase in the incidence of documentation of abuse inquiries from 5 percent in 1996 to 30 percent in 2002 at the intervention health centers, while it remained around 5 percent at the comparison site. Consistent with the intentions stated by project site clinicians in 2002, documentation of inquiry was found in records of 47 percent of the women patients who had undergone a complete physical in the previous year.

Beginnings: In 1996, mental health providers at community health centers were reporting domestic violence as an underlying factor in the conditions of up to 50 percent of the patients referred to them for treatment. Regional data were not consistently collected or reported in other systems; however, anecdotal data collected by health center staff seemed to suggest that the area around Rangeley in Franklin County (one of the four coalition sites) had a significant number of arrests in which domestic violence (DV) was considered a factor by the arresting officer. In Washington County, the site of the other three coalitions, there was evidence of above average rates of domestic violence, depression, and drug and alcohol dependence. To begin to increase awareness of the problem and connect victims with resources, the pilot program was initiated in 1996, with the implementation phases growing and expanding yearly.

Challenges and Solutions: Three of the four coalition sites are in the same county (Washington) and work together on collaborative regional strategies and with the local domestic violence provider agency. The fourth site, in Franklin County, is located in a remote area of the Western Mountains, far from DV and other provider agencies. The isolation affects staff morale, resource availability, opportunities for interagency

collaboration, and other factors that limit coalition progress and effectiveness.

The broad delineation of the project and insufficient coordination prior to the grant application brought all the coalitions into conflict with local DV victim services provider agencies and the statewide DV coalition. This was one of several frictions that had to be addressed by the project. The project was also challenged by high turnover of project management staff at both the state and local level. Finally, the project itself continues to search for additional funding sources to maintain key elements of the program beyond the CDC funding term.

Presentations of the project will be conducted in national and international conferences. MPCA has also convened a statewide “violence against women stakeholders group,” which intends to pursue policy changes and financial support to continue and extend the work begun during the CDC-funded IPV coalition project.

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