MULTI-FACETED STRATEGY TO COUNTER DOMESTIC ABUSE BY INCREASING AWARENESS AND FORMATION OF NEW ALLIANCES AMONG VESTED STAKEHOLDERS

By

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ABSTRACT

Domestic violence is a preventable public health problem that impacts one in four women during their lifetime. This project addressed domestic abuse in Marinette County, WI through a multifaceted approach of increasing awareness, alliance formation, and resource sharing between vested stakeholders of domestic abuse in the community. The objectives of the project were to:

1) Increase awareness among health care providers in Marinette County, WI regarding warning signs of domestic abuse, intervention strategies and local support resources
2) Help form alliance between major stakeholders to allow for resource sharing to best help domestic abuse victims of Marinette County, WI.
3) Increase local community awareness by initiating awareness campaign about domestic abuse with Project Give (not for profit organization)

Presentations were given to 56 health care providers in Marinette County addressing screening for domestic abuse, intervention strategies, and contact information for local domestic abuse shelter (The Rainbow House). As the second part of the project, new alliances were established by providing counseling to abuse victims through tele-psychiatry services at AHC. An AHC provider was selected to act as a liaison between AHC and the local shelter and was assigned a place on the board of directors of The Rainbow House to further cement this relationship.

Lastly, community awareness was increased through work with a local not-for-profit organization (Project Give). Project Give Back (packs) was initiated to collect school

supplies for families of abuse victims. New alliances were formed when the director of Project Give was invited to join the board of directors at The Rainbow House.

This project demonstrated that a multi-faceted approach to target domestic abuse through resource sharing between vested stakeholders can increase awareness and have a positive impact on countering domestic violence in communities.

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CHAPTER 1

INTRODUCTION

Background

Domestic abuse is defined as a pattern of assaultive and coercive behaviors that adults or adolescents use against their intimate partners, family members, elderly, and/or children. It can include physical violence and battery, sexual assault, psychological abuse, social isolation, and intimidation which often leave long lasting physical and emotional scars on the victims (American Medical Association [AMA], 1992; American Psychological Association [APA], 1996; Lewis, 2012).

Domestic abuse, also sometimes referred to as intimate partner violence, is a public health problem of epidemic proportions and prevalence and incidence rates in the U.S. have remained high despite best efforts. Approximately 85% of domestic abuse victims are women and it is estimated that domestic violence impacts one in four U.S. women during the course of a lifetime (Tjaden, 2000; Lewis, 2012). Review of the National Intimate Partner and Sexual Violence Survey done in 2001 showed that almost half a million American women experience physical violence by an intimate partner every year resulting in approximately 1500 deaths annually (Breiding, 2001).

Role of health care providers in addressing domestic abuse – Importance of screening

In addition to the immediate trauma caused by abuse, domestic violence can lead to a number of chronic health problems including depression, anxiety, chronic pain, and alcohol and substance abuse. Moreover, management of other chronic illnesses such as diabetes, hypertension, asthma and seizures can be problematic in victims of domestic

abuse due to accompanying psychological stress (AMA, 1992; APA, 1996). Though it is not possible to assign individual cost to the emotional burden faced by abuse victims, domestic violence does come with a high societal cost. It is estimated that domestic abuse results in an estimated annual cost of more than $8.3 billion in the U.S. (Max, 2004). Health care facilities are often the first point of contact for many of these victims and this places the health care system in a unique position where it can be a primary resource for victims of domestic abuse and can play a pivotal role in domestic violence prevention. A combined report by the Centers for Disease Control and Prevention (CDC) and National Institute of Justice (NIJ) showed that women make 693,933 visits to health care providers per year as a result of injuries due to physical assault (CDC and NIJ, 1998). The actual number is probably much higher as this study did not look at look at visits for psychological and chronic problems that can be sequelae of domestic abuse. This would make health care provider offices and emergency rooms across the country as ideal places to screen for domestic violence and act as first responders for guiding intervention (Davis, 2001; O'Doherty, 2014). Many studies have shown that routine and multiple screenings by skilled health care providers can significantly increase the identification of domestic violence (Hewitt, 2015; Valpied, 2015).

Health care providers have the unique ability to be the first responders in domestic violence and stop the cycle of abuse by intervening, promoting safety, and preventing the death of abuse victims (Hewitt, 2015). However, sadly, less than 10% of primary care physicians routinely screen for domestic violence during regular office visits (Rodriguez, 1999). Moreover, health care providers often treat domestic abuse victims without

inquiring about abuse even when faced with injuries that were obviously inflicted by someone else (Olive, 2007; Rodriguez, 1999).

The reasons for this are unclear. Uncertainty about how to ask patients about domestic violence, lack of knowledge and training about domestic abuse, ambiguity in practice guidelines, unfamiliarity with local domestic abuse intervention options, and insufficient time are some of the barriers identified to domestic abuse screening by health care providers (Nyame, 2013; Olive, 2007; Rose, 2010). There is an undeniable need for increasing awareness of domestic abuse among health care providers and improved training in this realm (Valpied, 2015).

Multi-faceted approach to address domestic abuse

Though the importance of routine domestic abuse screening by health care providers is well established, some recent reviews have suggested that screening might not be enough by itself to have a significant impact on domestic violence (Majzoub, 2015; O'Doherty, 2014). More and more experts are now calling for an integrated and multi-tiered approach relying on participation by vested stakeholders, and formation of new alliances to have a more meaningful and long lasting impact on domestic abuse identification and prevention (Clapp, 2000).

Marinette County, WI – Demographics and domestic violence incidence

Domestic abuse rates in Wisconsin have mirrored those in the rest of the country and have slowly been on the rise. The Wisconsin Domestic Abuse Incident Report (DAIR) published in 2014 documented 28,729 domestic abuse cases in 2012. Eighty one percent (81%) of the victims were female. Domestic abuse was defined in the report the same as under Wisconsin Statutes, s.968.075 as the "intentional infliction of physical pain, injury or

illness; intentional impairment of physical condition; sexual assault; or a physical act that causes the other person to reasonably fear that any of these actions will occur" (Wisconsin Domestic Abuse Incident Report [DAIR], 2012). This definition only applies to acts engaged in by an adult person against his or her spouse, former spouse, an adult with whom the person resides or formally resided, or an adult with whom the person has a child in common and does not include most cases of elder abuse or child abuse.

Marinette County (pop. 41,928) is located in the northeast part of Wisconsin and has a predominantly Caucasian population (98%). In the 2000 census, there were 17,585 households out of which 28.8% had children under the age of 18 living with them, and 56.4% were married couples living together. The county has a spread out population in terms of age with approximately 35% of the population between the ages of 18 and 44 years (US Census Bureau, 2015). In 2012, 145 new cases of domestic abuse were reported in Marinette County, WI, which is close to the state average (WI Domestic Abuse Incident Report [DAIR], 2012).

Observations as a health care provider in Marinette County, WI.

Observations on domestic abuse screening and intervention in the health care setting, over a span of almost 4 year formed the basis of this project:

1) Most health care providers did not routinely screen for domestic abuse as part of the patient encounter.
2) There were no established guidelines for domestic abuse screening or intervention to help guide health care providers
3) Most health care providers did not have a clear understanding of available local resources for domestic abuse

4) There was no full time psychiatrist, behavioral health specialist of domestic abuse counselor for Marinette County, WI.
5) There were no meaningful alliances between vested domestic abuse stakeholders in the community

CHAPTER 2

UNDERSTANDING THE PROBLEM OF DOMESTIC ABUSE IN MARINETTE COUNTY

Literature review

Pubmed database was used to do a thorough literature review on domestic abuse with special emphasis on role of screening, resource sharing, and alliance formation between involved stake-holders. Wisconsin statistics on domestic abuse were reviewed using Wisconsin Department of Justice Domestic Abuse Incident Report from 2012 (DAIR, 2012).

Major stakeholders of domestic abuse in Marinette County, WI.

As the next step of understanding the problem, we identified the major stakeholders of domestic abuse in Marinette County, WI.

1) Aurora Health Care (AHC) and its health care providers

Aurora Health Care is an integrated, not for profit, and all-for-people health care provider serving communities throughout eastern Wisconsin and northern Illinois. AHC provides the largest group of health care providers in Marinette County and has a good reputation for addressing health and wellness needs of the community. AHC provides services in primary health care (family medicine, internal medicine, obstetrics and gynecology) and specialty health care through a large team of physicians, surgeons, nurse practitioners (NP's), physician assistants, (PA's), registered nurses (RN's), licensed practical nurses (LPN's) and first-responders (paramedics) (Aurora Health Care website, 2015). AHC providers are often the first point of contact for domestic abuse victims in Marinette County.

2) The Rainbow House (Domestic abuse shelter)

The Rainbow House is the only domestic abuse shelter in Marinette County. It was established in 1978 and since then has been countering domestic abuse by providing shelter, emotional and legal support and counseling for domestic abuse victims and their families. The Rainbow house relies on grants and community donations for sustainability, maintenance, legal advocacy fees, and counseling sessions for victims. According to The Rainbow House website, in 2014, the shelter had 463 new clients (56 were accommodated in the shelter), provided 799 hours of legal advocacy and 807 hours of personal advocacy, and received over 400 crisis hotline calls (The Rainbow House website, 2015).

3) Victims of domestic abuse in Marinette County, WI

There are approximately 150 new cases of domestic abuse that are reported to the State from Marinette County each year (Wisconsin Domestic Abuse Incident Report [DAIR], 2012). The actual numbers are probably much higher as many victims do not seek help and chose to live with their perpetrators for a number of reasons that include fear, intimidation, embarrassment, and/or fear of rejection by community.

4) Community of Marinette County, WI

Most towns in Marinette County are small, the largest being Marinette city, with a population of approximately 10,000. The majority of the residents are white (98%) and share similar backgrounds. There are a few local community based, not-for-profit organizations, in Marinette County that support a number of causes. With the exception of The Rainbow House, none of them cater specifically to domestic abuse victims.

Identification of problem areas – Meeting with major stakeholders

As next step of the project, meetings with the leadership of the major stakeholders were arranged in order to acquire a better understanding of the domestic abuse problem in

Marinette County. Through this step insight was gained into the thought processes of the involved players, the unique challenges faced, and in turn a comprehensive picture of the overall situation was achieved. Information obtained was used to identify high priority focus areas and tailor a multi-faceted approach to counter domestic abuse in Marinette County.

Through meetings with leadership (administrative and clinical) at Aurora Health Care (AHC), the executive director of The Rainbow House (local shelter) and the director of Project Give over the course of several weeks, four problems areas were identified:

1) Awareness among health care providers

Most health care providers were not routinely screening for domestic abuse as part of the patient encounter. Even if domestic abuse was suspected or confirmed, there were no uniform protocols to guide support or intervention. In addition, health care providers had a very limited understanding of the local resources for domestic abuse. This combination of limited knowledge of domestic abuse among providers, and absence of institution-based tools to improve provider knowledge created a less than optimal environment for screening and management of domestic abuse victims.

2) Awareness among community

Many people in the community underestimated the long lasting physical, emotional and mental effects of domestic abuse on victims. There also appeared to be a misguided notion shared by many, that domestic abuse was private matter between two adults and best left to the involved parties to resolve differences. It also became apparent that there was a limited understanding (especially among the younger population) of the available local

resources for domestic abuse (shelters for abuse victims, social media apps, legal and psychiatric counseling, etc.)

3) *Lack of reliable local counseling services and behavioral health specialists*

Currently, there are no permanent behavioral health specialists available in the area for counseling and psychiatric treatment of domestic abuse victims. The Rainbow House had to schedule, arrange transportations, and make payments for counseling sessions for victims which imposed a high logistical and financial burden on the shelter.

4) Absence of resource sharing between stakeholders

The majority of the health care providers at AHC were not familiar with the services being offered at The Rainbow House and were referring abuse victims to Greenbay, WI, which was an hour drive. Understandably, many victims were hesitant to travel this far this due to limited financial and logistic means. Similarly, The Rainbow House staff had a limited understanding of counseling and treatment options that were available through the statewide network of AHC. Lack of communication, minimal overlap of personnel between facilities, and limited knowledge of domestic abuse related services offered by other local entities led to almost negligible resource sharing between the vested stakeholders of domestic abuse in Marinette County.

CHAPTER 3

METHODS

Based on the literature review, observations of health care providers in Marinette County and results of meetings with administration of AHC and The Rainbow House, three project objectives were identified. It was felt that these objectives best reflected a multi-faceted approach to address domestic violence in Marinette County through increasing awareness among the community members and health care providers and forming new alliances between vested stake-holders.

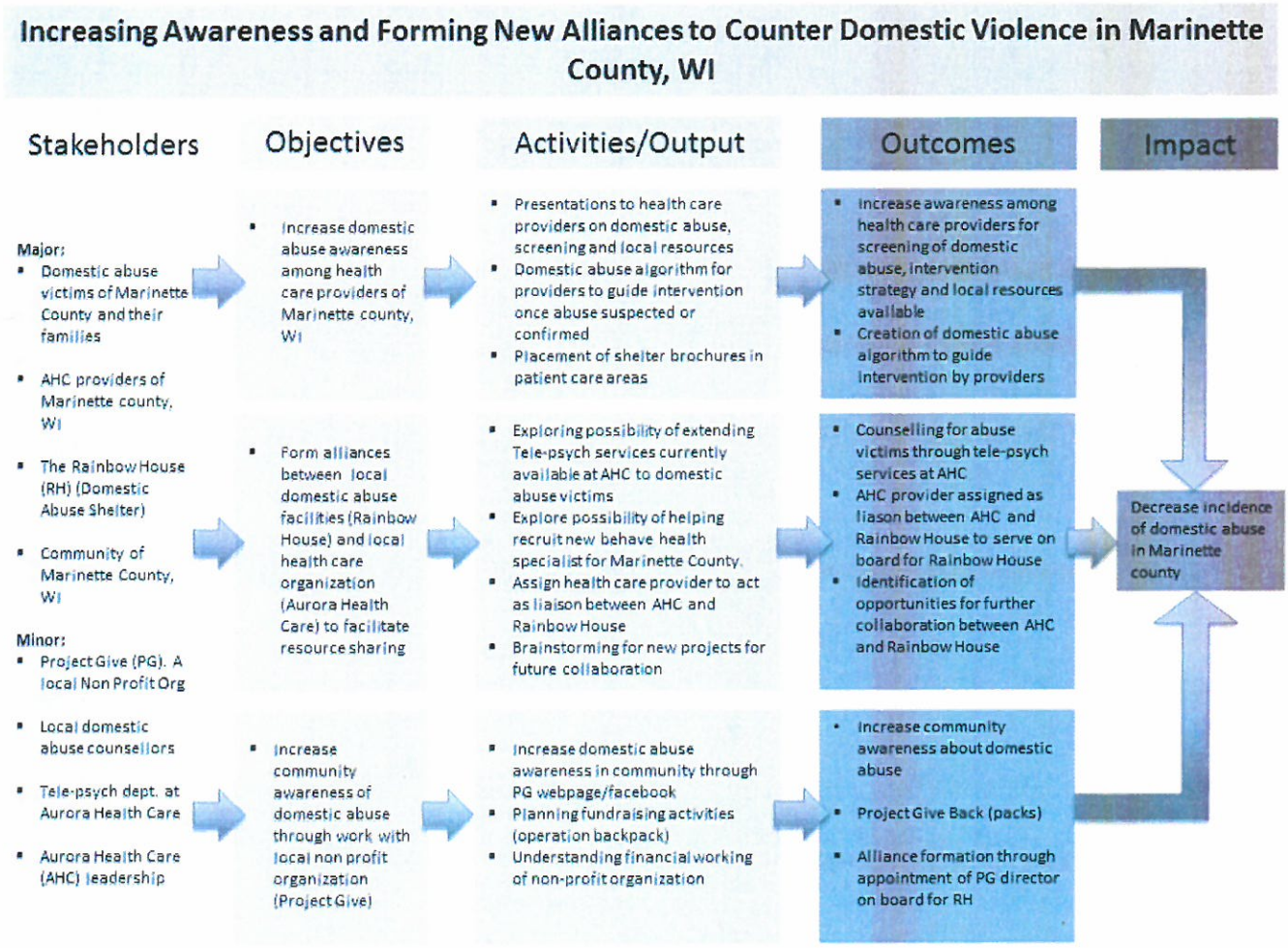
Aims and objectives of the project

1) Increase awareness among health care providers in Marinette County, WI regarding warning signs of domestic abuse, intervention strategies and local support resources
2) Help form alliance between major stakeholders to allow for resource sharing to best help domestic abuse victims of Marinette County, WI.
3) Increase local community awareness by initiating awareness campaign about domestic abuse with Project Give (not for profit organization)

Logic model for the project

Figure 3.1 summarizes the project in the form of a logic model, which gives a brief overview of the important elements of the project (stakeholders, objectives, activities, outcomes, and impact). The model was developed to help identify performance measures and aid with program planning. The stakeholders were categorized as major or minor based on whether they had a direct or indirect impact on domestic violence in Marinette

Figure 3.1. Logic model for the project.



County, WI. The objectives were determined to raise awareness, form local alliances, and facilitate resource sharing among vested stakeholders. Activities and outputs reflect actions that were taken to achieve the project objectives, outcomes specify the short-term accomplishments, while impact refers to the long-term outcomes that are expected to be achieved as a direct result of the project activities.

Project activities

Objective 1: Increase awareness among health care providers in Marinette County, WI regarding warning signs of domestic abuse, intervention strategies and local support resources

AHC departments and health care providers which would have the highest likelihood of initial encounter with domestic abuse victims were identified as targets for this objective. Selected departments included the emergency room, urgent care center, departments of family medicine and internal medicine, obstetrics and gynecology, general surgery and trauma, and medical and surgical inpatient floors of the Aurora Bay Area Medical Center in Marinette. Health care providers targeted included physicians, nurse practitioners, physician assistants, registered nurses (RNs), licensed practice nurses (LPN's) and emergency department paramedics. Arrangments were made with AHC administration and department chairs to give comprehensive presentations to health care providers at selected times. Given time constraints, presentation time was kept at approximately 5 minutes with alotted time at the end for questions and discussion. Refresher sessions were scheduled in some instances on request of health care providers, or to encourage additional provider involvement in certain departments. Snacks were often

served during these presentations as an additional incentive for participation. Individual and group sessions were planned based on provider availability and time. Care was taken to address reasons identified from the literature review as barriers for domestic abuse screening by health care providers: uncertainty about how to ask patients about abuse, lack of domestic abuse knowledge and training, ambiguity in practice guidelines, unfamiliarity with local domestic abuse resources, and insufficient time.

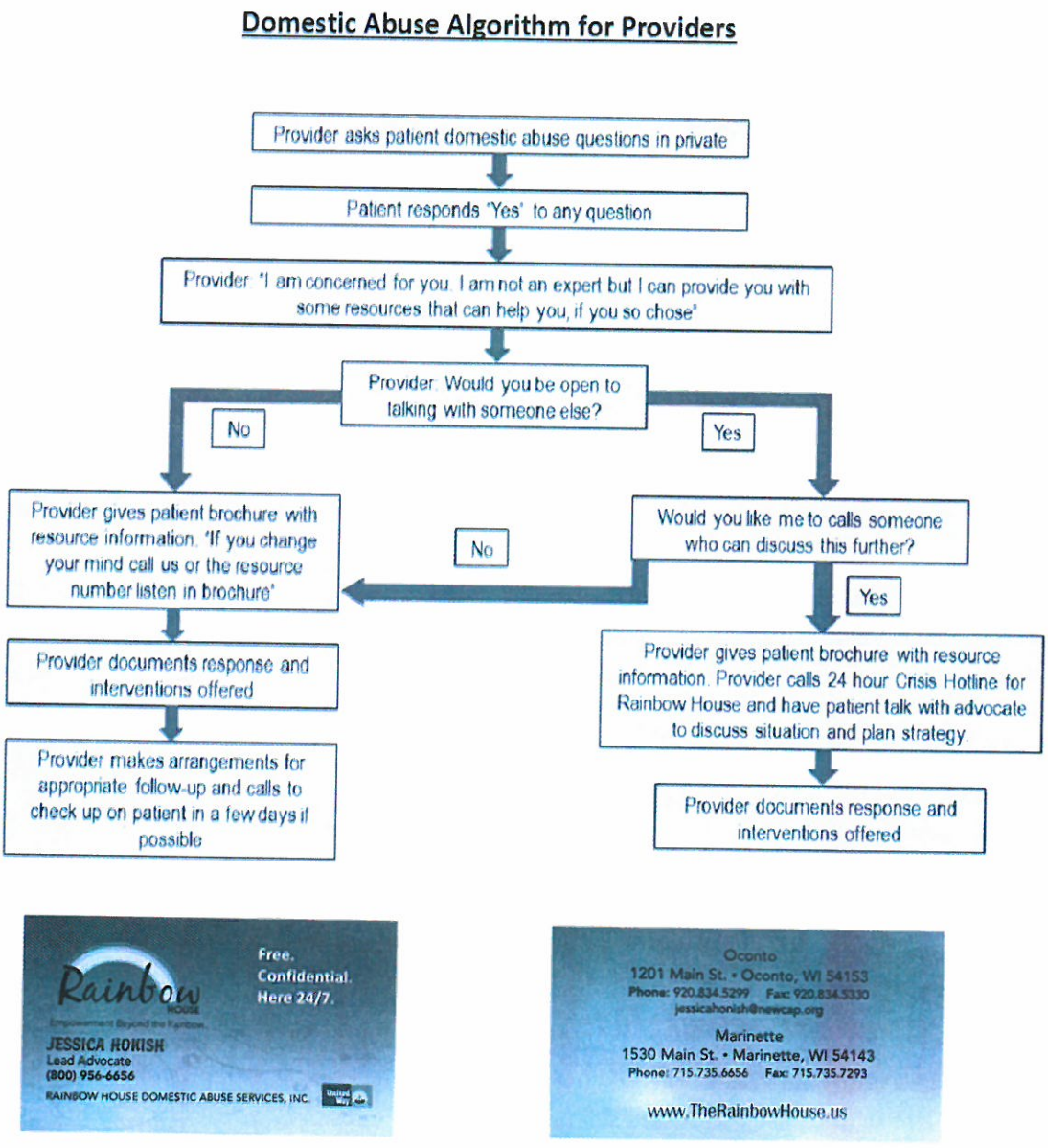
A power point presentation was provided and used concise evidence-based points to educate providers on basics of domestic abuse, risk factors, importance of screening during patient encounters, questioning techniques, examination skills, and intervention strategies. Using information gleaned from literature search, health care provider interviews and administration input, an algorithm was devised to guide providers in decision making once domestic abuse was suspected or confirmed. The algorithm (Figure 3.2) covered all potential scenarios in a step by step fashion with clear instructions on best way to respond to each scenario. If the victim indicated an interest in talking to someone about his/her abuse, the health care provider could directly connect to an on-call advocate from The Rainbow House through a 24 hour access number. The abuse victim and the on-call advocate could then together devise an intervention strategy that would work best in that particular situation. If the abuse victim was not open to talking with someone at the time of visit, 24 hour acess numbers were provided for on-call advocates at The Rainbow House in case the victim changed his/her mind. The algorithm also instructed the health care proivders to arrange for suitable follow up and document interaction for their own legal protection.

In addition, 'domestic abuse packets' were made for all patient care and waiting areas and included copies of domestic abuse algorithm for quick reference, brochures for The Rainbow House with list of services offered, and business cards for The Rainbow House lead advocate with 24 hour access numbers. Lastly, laminated copies of the domestic abuse algorithm were displayed on notice boards in provider offices and care areas for easy reference.

Objective 2: Help form alliance between major stakeholders to allow for resource sharing to best help domestic abuse victims of Marinette County, WI

Three areas in which the major stakeholders could benefit from resource sharing and opportunities for formation of new alliances and relationships were identified. First, meetings with AHC leadership were arranged to evaluate feasibility of recruiting a behavioral health specialist for the area who would also cater to the counseling needs of domestic abuse victims. Second, an options of extending tele-psychiatry services currently available to AHC patients in Marinette through a centralized Milwaukee based psychiatry group was explored. Tele-psychiatry is the use of information and communication technologies to provide psychiatric and counselling services remotely and has gained a reputation in the past decade as a safe, accessible and cost effective way of delivering psychiatric care to patients in underserved areas (Chakrabarti, 2015). Tele-psychiatry is currently available for Marinette County patients of AHC primary care providers through videoconferencing. A nurse is assigned responsibility of triaging and scheduling patients and maintaining followup while staying in close contact with the AHC Psychiatry department in Milwaukee, WI.

Figure 3.2: Domestic abuse algorithm for health care providers to guide intervention.



Third, the feasibility of assigning a health care provider with interest in domestic abuse as a liason between AHC and The Rainbow house was determined. This designated individual would maintain a channel for open dialogue between AHC and The Rainbow house, facilitating communication and interfacility referrals.

Objective 3: Increase local community awareness by initiating awareness campaign about domestic abuse with Project Give (not for profit organization)

A local not-for-profit organization, Project Give, was used as platform for this objective. After initial meetings with The Rainbow House leadership and director of Project Give, a two-pronged approach to achieve this objective was devised. First, a media campaign to increase domestic abuse awareness through Project Give webpage in the form of public service messages relaying abuse statistics and information on local resources was initiated. Second, Project Give Back (packs) was launched which aimed at increasing community awareness through collection of school supplies for families of domestic abuse victims at The Rainbow House. Initial target of collecting 50 backpacks filled with school supplies before start of school in August was set. In addition, high school students from the Marinette area were asked to help fill the backpacks with supplies and drop them at the shelter in order to further increase awareness about domestic violence among the youth of the community.

CHAPTER 4

RESULTS

This chapter provides results for the achievement of the three identified objectives.

Objective 1: Increase awareness among health care providers in Marinette County, WI regarding warning signs of domestic abuse, intervention strategies and local support

The presentations to AHC providers were made over a period of two weeks and were well attended. Attendance at these discussion events included 56 health care proivders (10 MD's, 27 RN's, 6 LPN's, 5 paramedics, 1 nurse practitioner, and 7 others) from five different departments (emergency department, family medicine, internal medicine, obstetrics and gynecology and general surger/trauma). These presentations were well received and generated healthy debate and sharing of ideas on how to improve the existing situation in the community. Domestic abuse screening for selected individuals (women over age 14, pregnant patients, new visits, annual visits and in patients with high suspicion for abuse) as part of review of systems was also discussed. Many providers were unaware that the shelter staff was available 24 hours a day for questions, arranged for counselling and legal advocacy, and could accommodate entire families free of cost.

Considerable time was given to reviewing the different scenarios covered in 'domestic abuse algorithm' (Figure 3.2). There was unanimous agreement that the proposed algorthim would help in taking care of domestic abuse victims in a responsible, safe and effective manner. There was also consensus that RN's and LPN's resposnible for checking in patients during doctor visits or hospital encounters would be the best personel for conducting the initial screening.

At three separate occasions, health care providers volunteered the story of a friend or family member who was a victim of domestic abuse locally. In all three instances, the involved health care providers resolved to convey information and 24 hour access numbers of The Rainbow House to the abuse victims and offer assistance as reviewed in earlier discussions.

Objective 2: Help form alliance between major stakeholders to allow for resource sharing to best help domestic abuse victims of Marinette County, WI

Considerable success was achieved in fulfilling this objective. Although recruiting a full time behavioral health specialist for Marinette County did not appear to be a feasible option at the current time due to fiancial and logsitic constraints, a sound strategy was devised and implemented for providing counselling to abuse victims through AHC tele-psychiatry services in Marinette County. AHC tele-psychiatry services were only offered to patients of AHC health care providers at the present time but many of the victims at The Rainbow House did not have AHC primary care providers or health care insurance. Wisconsin has not yet expanded Medicaid coverage to include low-income adults and Federally-faciliated Marketplace (FFM) has only started to offer health coverage in Wisconsin in 2015 (Medicaid.gov, 2015). These health coverage related challenges were overcome by grouping domestic abuse victims in Marinette County into five categories based on their primary care netowk and insurance status. Those with insurance and AHC primary care providers, would be directly referred to AHC tele-psychiatry for counselling, while those who had no primary care proividers or non-AHC primary care providers, would first be assigned AHC providers and then referred. Victims with no health insurance would be referred to AHC community service programs like Helping Hands or Community

Care for subsidized insurance and then referred for tele-psychiatry counselling (Table 4.1). This plan had the unanimous support of The Rainbow House and the AHC administration and was hailed as excellent opportunity for resource sharing and strengthening relationship between these two organizations.

Lastly, further success was achieved in fulfilling this objective through appointment of an AHC provider to act as liason between AHC and The Rainbow House. This provider was also given a position on the board of directors for The Rainbow House which would assure an open channel of communication between these two organizations and facilitate additional resource sharing and future collaborative efforts.

Objective 3: Increase local community awareness by initiating awareness campaign about domestic abuse with Project Give (not for profit organization)

An online campaign was lauched through Project Give Facebook page and aimed at increasing community awareness about domestic abuse. Weekly public awareness messages highlighting domestic abuse statistics, the role of community in countering domestic violence, and available local resources were posted from July through August, 2015. Many supportive comments were made and at least three people opened up with personal stories of abuse and the support they received locally.

Project Give Back (packs), aimed at collecting school supplies for families of domestic abuse victims in Marinette County, was a huge success and generated an overwhelming response from the community. The initial goal to collect 50 backpacks by return to school day in August 2015 was quickly met and almost 200 backpacks filled with school supplies were collected by the end of the collection period. In order to increase domestic abuse

Table 4.1: Grouping of domestic abuse victims based on health insurance and primary care provider status and strategy for enrollment in AHC tele-psychiatry program.

Group	**Health Insurance**	**Primary Care Provider**	**Strategy for enrollment in tele-psych**
A	Yes	AHC	Referral to tele-pscyh department
B	Yes	Non AHC	Change to AHC provider and then tele-psych referral
C	Yes	None	Assign AHC provider as PCP and then tele-psych referral
D	No	No	Refer to patient advocacy office for helath insurance through community plans (Helping Hands and Community Care) to provide insurance and then assign AHC PCP and tele-psych referral
E	No	AHC	Insurance through Helping Hands or Community Care and then tele-psych referral

awareness among the youth of Marinette County, 10 local high school students were asked to helped fill and distribute the school bags. Extra backpacks were distributed to underprevileged families in the community who were identified by Project Give supporters.

Additional Project Give activities were planned for the future in conjunction with The Rainbow House to further increase community awareness about domestic abuse. The director of Project Give was invited to join the board of directors of The Rainbow House which can be the start of a long and fruitful partinership that will increase community awareness, and over time help decrease incidence of dometic abuse in Marinette County.

CHAPTER 5

DISCUSSION

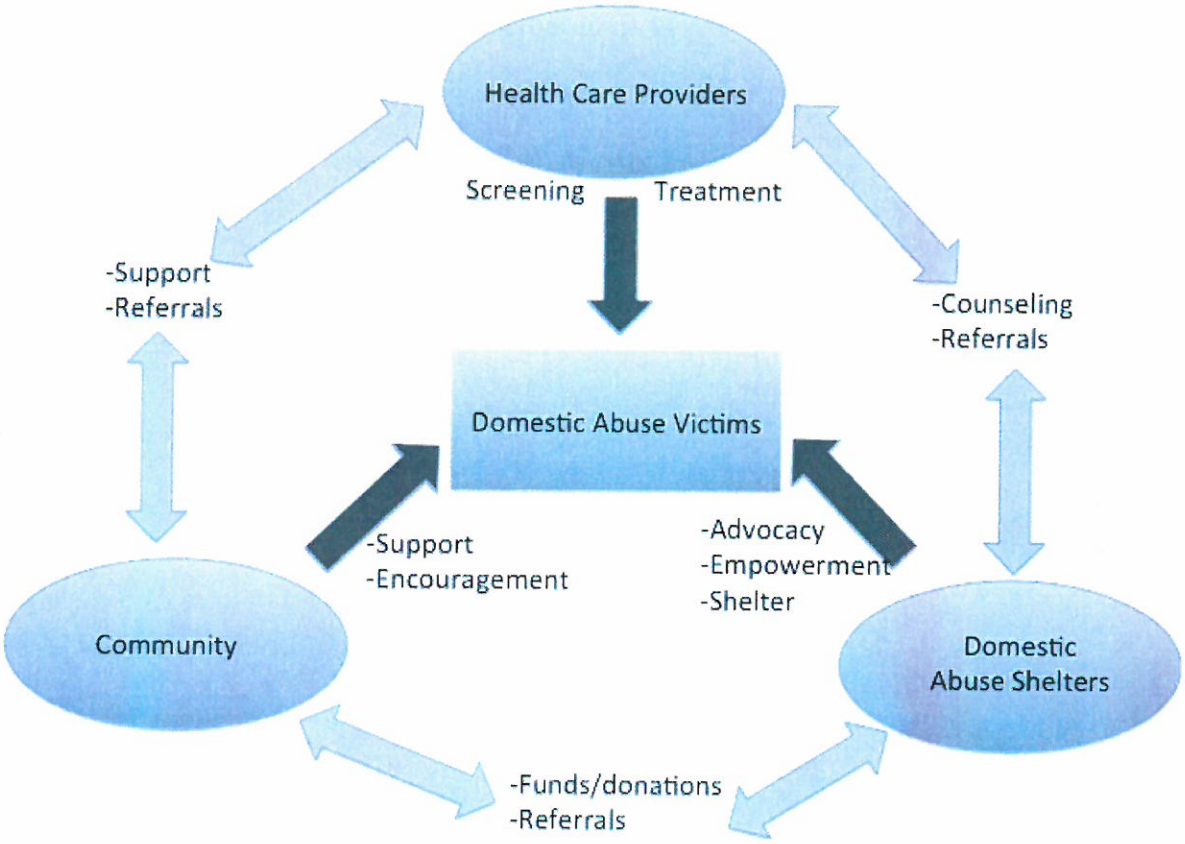
Domestic abuse is experienced by approximately one in three women during the course of a lifetime, and has serious physical and emotional health consequences (Lewis, 2012). Identifying and taking care of abuse victims can be challenging as many of them do not voluntarily seek help. There are a number of reasons for this behavior which includes intimidation and fear of additional abuse, fear for the well-being of children, fear of isolation from the community and lack of awareness of the available local resources for seeking help (Feder, 2011; Mazza, 2000). Studies have shown that very few abuse victims seek support from services for abuse victims (eg. local shelters) because most are not ready or not able to do so, instead turning first to family and friends and then to health professionals (Rees, 2014). Even when the victims try to confide in friends or family they are often told that it is their fault or that it is a personal matter and they need to settle their differences with the abuser on their own. Sadly, the response from health care professionals can be equally unhelpful despite the fact that health care providers are often the first or only point of contact for domestic abuse victims and are uniquely positioned to identify abuse victims, provide support, and refer to community resources (Feder, 2011).

It has been shown quite clearly that routine screening for domestic abuse can increase early detection and provide opportunity to stop the cycle of abuse (Hewill, 2015; Olive, 2007). However, studies have also shown that less than 10% of primary care providers routinely screen for domestic abuse and even when abuse is suspected, heath care providers are more concerned with managing physical and emotional injuries from abuse rather than implementing interventions to empower victims, promote safety, and

refer to community resrouces (Rodriguez, 1999). Though screening for domestic abuse by health care providers is important, it is imperative that health professionals have a clear strategy that goes beyond screening alone for intervening and promoting safetly of abuse victims. Providers need to be well aware of the local resources available for community support, counselling, advocacy, and shelter in order to provide holistic care to the victims with the maximum chances of success (Feder, 2011; Rees, 2014; Valpied, 2015).

Over the past few decades, many different strategies focusing on different areas have been described to counter domestic violence; yet, we still have to see a meanginful decrease in rates of domestic abuse (O'Doherty, 2014; Taft, 2013). One reason for this lack of progress is that current strategies focus only on one or two variables of domestic abuse instead of adopting a more holistic approach to counter domestic violence. A succesful strategy for decreasing rates of domestic abuse in communities must be multi-faceted and rely on equal participation from all major stake holders in order to ensure support at all stages of the abuse cycle. Community members, health care providers and domestic abuse facilities are the three major stakeholders of domestic abuse in a community and must be be targetted individually and cummulatively, in order to have a meaninful impact on the battle against domestic abuse. Figure 5.1 illustrates the complex interplay between the major stakeholders of domestic abuse in communities and the opportunities for resource sharing among them which can positively impact care of domesic abuse victims.

Figure 5.1: Diagramatic illustration of complex relationship between major stakeholders of domestic abuse in communities



Considerable success was achieved for all three of the project objectives. Specialties that would have the highest chance of encountering domesic abuse victims (primary care and internal medicine providers, obstetrics and gynecology, emergency medicine and

general surgery/trauma) were identified and the message about domestic abuse screening and intervention was conveyed to the majority of the health care providers of these specialities in Marinette County, WI. It seemed that the health care providers in general underestimated the extent of domestic abuse in communities and were routinely screening for medical conditions that were far more uncommon than domestic abuse. Additionally, most health care providers were unaware of the extent of services provided by The Rainbow House in the community and had instead opted to transfer care of some domestic abuse victims to another community, which posed significant logistical and financial challenges for the victims. One of the major reasons health care providers were uncomfortable initiating discussion with suspected victims of abuse was due to limited knowledge of how to proceed once abuse was confirmed and the perception that active particiaton would require too much time and increase legal vulnerability. Health care providers also showed considerable interest in the "domestic abuse provider algorithm" and commented that the step wise approach of the algorithm would save time and help to direct victims to local resources in an efficient and safe manner with legal protection. The idea of placing The Rainbow House brochures with the 24 hour access line numbers in the patient waiting areas was also viewed very favorably in potentially helping a victim or a victim's family or friend to reach out and seek help independently.

The second objective of promoting alliance formation and resource sharing among major stake holders was also achieved. Clear guidelines were established for inclusion of domestic abuse victims seen at The Rainbow House in the tele-psychiatry program at AHC based on their insurance and primary care network. This allowed domestic abuse victims in Marinette County to have access to counselling services and psychological support

through behavioral health specialists in Milwaukee, WI which in turn created a mutually beneficial partnership between The Rainbow House and AHC. The Rainbow House will no longer have to overcome logistical and financial challenges involved in transportation of abuse victims to counselors in distant areas and AHC will see an increase in patients enrolled in primary care networks. The alliance between AHC and The Rainbow House was further strengthened through appointment of an AHC provider on The Rainbow House board of directors as a liason between the two entities. This appointment will strengthen and streamline existing channels of communication between the two entities, allow for resource sharing, and form the foundation of a long and mutually beneficial relationship that will positively impact the management of domestic abuse in Marinette County.

The last objective of increasing domestic abuse awareness among the community of Marinette County through work with Project Give was achieved as well. Messages about domestic abuse on the organization's webpage generated interesting comments and inspiring stories. Many of the issues pertaining to social stigma associated with domestic abuse victims and the absolute need for community support to address this growing epidemic were also addressed. The support that the community of Marinette County showed towards Project Give Back (packs) was exceptional and allowed collection of almost 200 backpacks filled with school supplies for children of domestic abuse victims and other underprevileged families of Marinette County. The initial target of 50 backpacks was significantly exceeded and indicated that the local community felt strongly on the subject of domestic abuse and support could be vital in helping decrease rates of abuse in Marinette County. The appointment of the Project Give director on the board of The Rainbow House will give the community of Marinette County a unified and organized voice

in deciding future Rainbow House policies and will open the doors for new relationships and alliances between these two organizations on the domestic abuse front. The two organizations already exploring future opportunities for collaboration through web-based blogs and forums, and online chat-rooms to further increase community awareness about domestic abuse in Marinette County.

Limitations

The project was limited by lack of quantitative data and demonstration of long term results. Inclusion of pre and post intervention surveys could have helped to better quantify interventions to increase awareness among community and health care providers. Studies are needed to prospecitvely follow rates of domestic violence in Marinette County, WI and determine feasibility of implementation of described intervention in other communities across Unites States.

Conclusion

In conclusion, the described model for a multi-faceted and multi-tiered approach with focus on increasing collaboration and resource sharing among vested stakeholders can be an effective strategy for reducing rates of domestic abuse in communities across the country. This integrated appcoach can help provide holistic care to domestic abuse victims through earlier identification, empowerment, and timely referral to local shelters and counselling facilities, and help decrease incidence and prevalence of domestic abuse over time.

REFERENCES

American Medical Association (AMA). (1992). American Medical Association diagnostic and treatment guidelines on domestic violence. *Arch Fam Med*, 1, 39-47

American Psycological Association (APA). (1996). Report of the American Psychological Association Presidential Task Force on violence and the family. Washington DC.

Aurora Health Care. (2015). Website. Retrieved from https://www.aurorahealthcare.org/about-aurora

Breiding, MJ., et al. (2001). Prevalence and characteristics of sexual violence, stalking and intimate violence victimization – National Intimate Partner and Sexual Violence Survey, US, 2001. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6308a1.htm?s_cid=ss6308a1_e

Chakrabarti, S. (2015). Usefulness of telepsychiatry: a critical evaluation of videoconferencing based approaches. *World J Psychiatry*, 5(3), 286-304

Clapp, L. (2000). Ending domestic violence is everyone's responsibility: an integrated approach to domestic violence treatment. *Nurs Clin North Am*, 35(2), 481-8

Davis, RE., Harsh KE. (2001). Confronting barriers to universal screening for domestic violence. *J Prof Nurs*, 17(6):313-20

Feder, G., Davies, RA., Baird, K., et al. (2011). Identification and referral to improve safety (IRIS) of women experiencing domestic violence with a primary care training and support program: a cluster randomized control trial. *Lancet*, 378, 1788-95

Hewitt, LN. (2015). Intimate partner violence: the role of nurses in protection of patients. *Crit Care Nurs Clin North Am*, 27(2), 271-5

Lewis, J. (2012). Domestic violence. A preventable public health problem. Retrieved from http://centerfortotalhealth.org/domestic-violence-a-preventable-public-health-problem/

Majzoub Perez, K., et al. (2015). Behavioral health integration in primary care at Brigham and Women's Advanced Primary Care Associates, South Huntington. *Healthc (Amst)*, 3(3), 169-74

Max, W., Et al. (2004). Econmic toll of intimate partner violence against women in the United States. *Violence Vict*, 19(3), 259-72

Mazza, D., Lawrence, JM., Roberts, GL., Khowlden, SM. (2000). What can we do about domestic violence? *Med J Aust*, 173(10), 532-5

Medicaid.gov (2015). Keeping America Healthy. Official website. Retrieved from http://www.medicaid.gov/medicaid-chip-program-information/by-state/wisconsin.html

National Institute of Justice (NIJ) and Centers for Disease Control and Prevention. (1998). Prevalence, incidence and consequences of violence against women: Findings from the National Violence Against Women survey. Washington DC.

Nyame, S. Howard, LM., Feder, G., Trevillion, K. (2013). A survey of mental health professionals' knowledge, attitudes and preparedness to respond to domestic violence. *J. Ment Health*, 22(6), 536-43

O'Doherty, LJ., et al. (2014). Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis. *BMJ*, 348, g2913

Olive, P. (2007). Care for emergency department patients who have experienced domestic violence: a review of the evidence base. *J Clin Nurs*, 16(9), 1736-48

Project Give. (2015). Community organization. Retrieved from https://www.facebook.com/projectgive906

Rees, S. Silove, D. (2014). Why primary health care interventions for intimate partner violence do not work. *Lancet*, 384, 229

Rodriguez, M., Bauer, H., McLoughlin, E., Grumbach, K. (1999). Screening and intervention for intimate partner abuse: Practices and attitudes of primary care physicians. *JAMA*, 282(5),

Rose, D., et al. (2010). Barriers and facilitators of disclosures of domestic violence by mental health service users: a qualitative study. *Br. J. Psychiatry*, 198(3), 189-194

The Rainbow House. (2015). Website. Retrieved from http://therainbowhouse.us/

Tjaden, P., Thoennes N. (2000). Full report of the prevalence, incidence, and consequences of violence against women. Findings from the national violence against women survey. *NIJCDC*. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/183781.pdf

United States Census Bureau. (2015). Quick facts. Retrieved from http://quickfacts.census.gov/qfd/states/55/55075.html

Valpied, J. Hegarty, K. (2015). Intimate partner abuse: identifying, caring for, and helping women in health care settings. Womens Health(Lond Engl), 11(1), 51-63

Wisconsin Department of Justice Domestic Abuse Incident Report (DAIR), 2012. Released May, 2014. Retrieved from http://www.doj.state.wi.us/sites/default/files/ocvs/not-victim/domestic-abuse-incident-report-2012-20140530.pdf