

**Health Resources and Services Administration**

**National Family and Intimate Partner  
Violence Prevention Initiative**

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*Action Plan To Prevent  
Family and Intimate Partner Violence*

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Health Resources and Services Administration  
Office of Minority Health**

**OFFICE OF MINORITY HEALTH**

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## ***FOREWORD***

The *HRSA Action Plan to Prevent Family and Intimate Partner Violence* is about making a difference. It is about bringing support to families in chaos. It is about community-wide involvement in violence prevention. The devastating effects of family and intimate partner violence reach outward from the immediate family into the extended family, the neighborhood, the workplace, the community, the service system, and society. While the true magnitude of this problem is unknown, what is known suggests a public health epidemic just as serious as any faced today. The costs to the safety, health, and well-being of individual children, adolescents, parents, partners, and elders are immeasurable. No one is immune. Everyone is at risk. This epidemic affects everyone—and everyone can play a role in its prevention.

In 1995, the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, launched the **National Family and Intimate Partner Violence Prevention Initiative**. The purpose of the Initiative was to formulate an Action Plan to guide HRSA's response to family and intimate partner violence through the end of the 20th century and into the 21st. HRSA has leadership responsibility for health service and professional workforce issues related to access, equity, quality, and cost of care, and pursues these responsibilities by providing leadership to assure the support and delivery of primary health services, especially to disadvantaged populations and those with special health care needs.

This Action Plan symbolizes HRSA's commitment to make the prevention of family and intimate partner violence an Agency priority. HRSA recognizes that no single Federal agency has the resources or capacity to do the job alone; therefore, it is looking to join forces with other Federal agencies, State and local governments, professional associations, foundations, universities and colleges, corporations and businesses, community groups, and individuals to bring this epidemic to an end. Five components—policy, training, service delivery, family education and prevention promotion, and research and evaluation—focus the activities of the Action Plan. While specific goals and strategies are identified for each of the components, other strong messages are woven throughout the Plan:

- C The agenda for improving the health care system's response to family and intimate partner violence must be comprehensive, family centered, integrated, flexible, responsive to cultural and linguistic concerns, and outcomes oriented.
- C Interdisciplinary training and education to increase the competency of the health care workforce in violence prevention, screening, and treatment are the building blocks to a responsive system of care.
- C Family and intimate partner violence must be fought through well-crafted educational programs that reach both those who need help and those who can help. Recruitment of males in violence prevention efforts is critical.

- C Transferring knowledge and research on family and intimate partner violence to the health care workforce within communities is critical to strengthening protective factors in individuals and families.
- C Effective violence prevention activities are those that involve the community—the consumers—in planning right from the start.

While the reduction of family and intimate partner violence is not a new focus for HRSA, the Initiative which began in 1995 marked the beginning of a new vision of HRSA's role in addressing this public health problem. The *Action Plan to Prevent Family and Intimate Partner Violence* presents a blueprint for taking the next steps to break the cycle of violence in our families.

HRSA is using its network of community and migrant health centers, programs for mothers and children, rural health programs, and its health professions training programs and programs for special populations as the centerpiece of its response. The mechanisms that HRSA has established to monitor the Agency's violence prevention activities ensure that action steps are developed and resources are directed toward activities that are responsive to the goals and actions outlined in this Action Plan.

Equally important to HRSA's success is the development of partnerships with other Federal agencies and the private sector to address policy and program issues presented in the Action Plan. Communities are also encouraged to examine carefully the goals and actions presented in this document and either select those most appropriate to their programs and populations or use them as a springboard for developing other ones.

/s/

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Acting Administrator

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# ***INTRODUCTION***

The Health Resources and Services Administration's (HRSA) *Action Plan to Prevent Family and Intimate Partner Violence* is about HRSA making a difference in the health care system's response to a problem of epidemic proportions. Family and intimate partner violence encompasses a range of violent, abusive, and neglectful behaviors within families and in intimate relationships. The exhibit on the following page, *The Scope of Family and Intimate Partner Violence*, captures the many facets of the problem.

HRSA can plan, implement, and evaluate family and intimate partner violence prevention activities in the areas of Policy, Training, Service Delivery, Family Education and Prevention Promotion, and Research and Evaluation. Goals and actions defined by HRSA for each of these areas are detailed in Chapters I through V of this Action Plan. Appendix A presents the Action Plan Development Process, providing information on the Planning Committee Meeting and the National Invitational Meeting, along with a listing of the HRSA Steering Committee members and Office of Minority Health staff instrumental in the development process. Appendices B and C, respectively, present listings of the Planning Committee Meeting and National Invitational Meeting participants. Appendix D provides a listing of suggested resources, and Appendix E presents selected materials from the National Invitational Meeting.

## ***What Is Known About Family and Intimate Partner Violence?***

Researchers agree that family members and partners who engage in any one form of violence are likely to engage in other forms of violence. For example, studies show that partner abuse and child abuse occur together in the same family 50 to 70 percent of the time (Walker, 1985 and Sheahan, 1991). The financial, physical, and emotional costs of family and intimate partner violence are high. Within the immediate family, both victims and witnesses are known to suffer long-term effects, including physical illness, depression, and loss of self-esteem. The Corporate Alliance to End Partner Violence reports that, nationally, businesses lose more than \$4.5 billion every year due to the consequences of partner abuse through absenteeism, health care costs, high worker turnover, and lower productivity (CAEPV, 1996).

### ***Child Abuse and Neglect***

Over the past 30 years, all major causes of childhood death from injury and disease have declined, except one—**violence**. Homicide of young children has nearly doubled, and homicide and suicide of older children have nearly tripled (Singh and Yu, 1996). The National Center on Child Abuse and Neglect (NCCAN) sponsors national incidence studies on violence involving children. Its 1996 study reveals an alarming increase in abused and neglected children, from 1.4 million in 1986 to 2.8 million in 1993. Over the same period,

## *The Scope of Family and Intimate Partner Violence*

### *Partner Abuse*

- # physical abuse
- # emotional abuse
- # sexual abuse
- # verbal abuse
- # coercion
- # economic abuse
- # spiritual abuse
- # isolation and intimidation
- # use of children to gain power

T	by spouse
T	by intimate partner (including same-sex partners)

### *Parent/Elder Abuse*

- # physical abuse
- # emotional abuse
- # sexual abuse
- # verbal abuse or coercion
- # neglect or abandonment
- # institutional abuse
- # other abuse outside the home
- # economic abuse/financial exploitation

T	by minor and adult children
T	by extended family members
T	by other elders (including partners)
T	by formal and informal caregivers

### *Child/Adolescent Abuse*

- # physical abuse
- # neglect or abandonment
- # emotional abuse
- # sexual abuse
- # system or institutional abuse
- # being witness to physical abuse of  
family member
- # sexual exploitation (e.g.,  
prostitution and pornography)
- # abuse outside the home (e.g., in  
foster care, school, church, and

T	by parents
T	by family members
T	by caretakers
T	by intimate friend(s) of parent(s)
T	by adults who frequent the household
T	by siblings
T	by other children

recreational settings)

the number of children who were seriously injured as a result of maltreatment quadrupled from nearly 142,000 to nearly 570,000. Maltreated children are at high risk for such problems as developmental delays, school-related problems, drug abuse, and physical and emotional problems throughout their lives (NCCAN, 1988). Youth in detention facilities frequently report histories of physical and sexual abuse (Sheahan, 1991). Research also suggests a link between child sexual abuse and teen pregnancy. Teens who are victimized as children tend to engage in sexual intercourse earlier, and are less likely to use contraceptives, than non-abused teens (Boyer and Fine, 1992).

### ***Partner Abuse***

Partner abuse encompasses a broad range of behaviors on the part of the abuser to isolate and gain control over the victim. A 1985 National Family Violence Survey found that more than 3 out of every 100 women were severely assaulted (e.g., punched, kicked, choked, or had a knife or gun used on them) by their partners during the previous year. The CAEPV reports approximately 13,000 acts of violence against women at work each year by husbands or boyfriends. A Federal Bureau of Investigation study found that approximately 28 percent of the 5,373 female homicides in the United States in 1992 were women murdered by their husbands or boyfriends (FBI, 1994). The impact of partner abuse on health care resources is tremendous. Approximately 11.7 percent of women who seek hospital emergency room treatment do so for battering-related injuries (Abbott et al, 1995). In addition to physical injuries, victims experience many other types of health problems, including: depression; post-traumatic stress disorder; eating and sleeping disorders; substance abuse; hypertension; chronic pain or fatigue; and miscarriages (Shelley, 1995). Pregnant women and their unborn children are particularly vulnerable—violence often occurs for the first time or escalates during pregnancy (McFarlane et al, 1992). Victims of partner abuse and their abusers come from all income levels and cultural backgrounds. According to Hadley (1996), few victims openly disclose the violence in their lives due to shame, awkwardness, and fear of not being believed or of being blamed.

### ***Parent/Elder Abuse***

The elderly are not safe from maltreatment. Elder abuse occurs both in families and in institutions. Because abused and neglected elderly persons are often isolated in society, in their communities, and in their own homes, the extent of elder abuse is largely unknown. The National Center on Elder Abuse estimates that between 1.5 and 2 million people in the United States over the age of 65, or about 5 percent of the elderly population, are abuse victims each year. The National Center on Elder Abuse found that 241,000 cases of elder abuse were reported to authorities in 1994. Based on the limited research on elder abuse, the factors that seem to be the most likely are the unhealthy dependency of the abuser on the elder and vice versa, the psychological state of the abuser, the physical and/or mental condition of the elder, the social isolation of the family, and a continuation of partner abuse into the older years. As explained by Campbell (1996), most elderly victims do not know where to go for help or are too ashamed to tell anyone about the abuse. In situations where elderly parents are abused by adult children in care-giving roles, the lack of support for the care giver frequently intensifies the problem.

## ***What Are the Critical Issues in Violence Prevention?***

The critical issues in the prevention of family and intimate partner violence which form the basis of this Action Plan are described below.

***Cultural Competency***—Effective prevention of family and intimate partner violence hinges upon the development of cultural competency within the health care workforce. As defined by HRSA, cultural competency is: *A life-long process which includes the examination of one’s own attitudes and values, and the acquisition of knowledge and appreciation of cultural differences and similarities within, among, and between groups, resulting in skills and behaviors that facilitate the provision of quality and acceptable primary health care and health education to underserved and vulnerable populations. A culturally competent agency honors and respects beliefs, interpersonal styles, attitudes, and behaviors of individuals who are clients, as well as the multi-cultural staff who are providing services at the level of policy, administration, practice, and advocacy. In addition, the agency: (1) demonstrates the capacity for cultural self-assessment; (2) conducts cultural-based needs assessments for service planning purposes; (3) incorporates cultural knowledge into primary care practice; and (4) develops and maintains a staff that is reflective of the client population.*

***Professional Training***—Health care providers need training, protocols, and “best practice” models on how to identify and intervene effectively with families or individuals experiencing, or at-risk for, violence. Further, representatives of underserved populations need affordable, available, and accessible training to be able to enter the health care workforce.

***Screening***—Family and intimate partner violence victims and their abusers are greatly under-identified by health care providers, making routine screening a critical need. Providers must be prepared to screen the same patients repeatedly, in that many patients may not be ready to disclose the violence in their lives the first time that they are screened.

***Managed Care*** —Family and intimate partner violence prevention detection and treatment services must be integrated into the managed care arena to allow for family or individual access to needed services.

***Community Education***—There is a need to educate the media, employers, and the general public about the causes, dynamics, and characteristics of family and intimate partner violence and the options for intervention and prevention. Many individuals do not see themselves or others as victims of violence or as abusers, and those who do often do not realize that health care providers are a resource.

***Funding***—Federal, State, and community agencies must redefine their funding streams and pool financial resources for family and intimate partner violence prevention initiatives to offset the

escalating uninsured population, cuts in programs for immigrants, and the potential impact of public welfare reform on families.

***Mental Health***—Mental health is a critical violence prevention issue. Mental health services and their promotion must become integral components of the health care system’s response to family and intimate partner violence.

***Prevention Message***—A national multi-lingual health promotion campaign must make it clear that: (1) family and intimate partner violence is a preventable public health epidemic which impacts everyone and is intolerable in any shape or form, and (2) everyone has a right to be safe in their home, workplace, and community.

***Standardized Definitions***—Standardized operational definitions of family and intimate partner violence must be developed by HRSA and utilized by policy makers, researchers, and service providers, in order to ascertain the true extent of the problem and determine whether progress is being made in prevention.

***Research***—There is a critical need for the coordination of research on family and intimate partner violence at the Federal level in the areas of incidence and prevalence, health care and social costs, mental health consequences, characteristics of effective screening, prevention, and service approaches, as well as intervention and service outcomes. Research must encompass underserved populations (e.g., the poor, the elderly, migrants, immigrants and refugees, individuals with disabilities, the incarcerated, lesbian and gay communities, minority youth, and so on), and both victims and abusers.

***Collaboration***—Federal leadership is needed to develop and implement a collaborative, comprehensive, interdisciplinary approach to family and intimate partner violence and a continuum of community-based care. Resources at all levels—Federal, State, local, public, and private—need to be pooled into a strong and united force.

***Community Ownership***—Community-based coalitions involving community leaders, advocates, victims, survivors, and consumers (including men and indigenous populations) are essential to community ownership in family and intimate partner violence prevention. Promising vehicles for prevention exist (e.g., neighborhood family centers, home-visiting programs, senior-to-senior peer counseling, school-based counseling, work-based programs, and hospital-based screening); however, Federal leadership is needed to help communities organize and pursue these vehicles.

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## ***I. POLICY***

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HRSA policies to advance the prevention of family and intimate partner violence cross-cut four major areas of the Agency's responsibility: Health Professional Training; Service Delivery; Family Education and Health Promotion; and Research and Evaluation. The policy actions described herein promote: (1) cultural competency in HRSA-funded programs and in the health care provider workforce; (2) a focus on mental health in health care service delivery, research, professional training, and family and community education; (3) the universal use of screening measures by health care providers to identify violent and at-risk families; (4) Federal leadership and collaboration at all levels—Federal, State, local, public, and private; and (5) the use of standardized operational definitions of family and intimate partner violence by HRSA staff and grantees.

### ***GOAL 1***

#### ***Ensure the Incorporation and Promotion of Cultural Competency When Addressing Family and Intimate Partner Violence***

#### ***ACTIONS***

- A. Mandate that all Bureaus and Offices incorporate cultural competency principles in the development of program guidances, announcements, requests for proposals, publications, and training materials.
- B. Establish a mechanism for involving advisory groups of diverse cultural and ethnic backgrounds to provide guidance to HRSA at all levels in the development of programs, research activities, and evaluation studies relevant to family and intimate partner violence.
- C. Initiate and/or expand inter-governmental and intra-governmental agency discussions on family and intimate partner violence that focus on the sharing of agency definitions, policies, and practices relevant to cultural competency.
- D. Mandate that HRSA-funded initiatives (education and training, prevention promotion, service delivery, and research) related to family and intimate partner violence incorporate principles and practices of cultural competency into policy decision making and program development.
- E. Work with national advocacy organizations and State and local governments to facilitate the sharing of culturally competent programs, policies, practices, and training materials among health care decision and policy makers, educators, and service providers.

## ***GOAL 2***

### ***Promote the Integration of Mental Health Care into Initiatives Addressing Family and Intimate Partner Violence***

#### ***ACTIONS***

- A. Collaborate with mental health public and private agencies and organizations on the mental health issues surrounding family and intimate partner violence and ways to address these issues through HRSA-funded programs.
- B. Support funding of family and intimate partner violence prevention initiatives that promote both physical and mental health.
- C. Identify and disseminate to HRSA-funded health care providers and training institutions model cross-system protocols that focus on both the physical and mental health aspects of family and intimate partner violence to facilitate an integrated approach to prevention and treatment.

## ***GOAL 3***

### ***Support the Universal Use of Routine Family and Intimate Partner Violence Screening Measures***

#### ***ACTIONS***

- A. Initiate and/or expand inter-governmental and intra-governmental agency discussions that focus on sharing family and intimate partner violence screening policies, protocols, and practices.
- B. Establish a multidisciplinary and multi-cultural advisory committee to assist HRSA in identifying various types of screening measures and the critical components of those measures.
- C. Support mechanisms for pilot testing the reliability, validity, and adaptability of various types of screening measures in HRSA-funded programs.
- D. Provide training to HRSA Bureau and Office staff (e.g., through the HRSA Colloquia Series) on the incorporation of screening measures into HRSA-funded programs.
- E. Support funding for grant applications that incorporate: (1) promotion of and guidance on the use of screening measures in health professions education/training; and/or (2) implementation of routine screening measures into service delivery.

- F. Work with continuing education and professional accreditation organizations to advance the universal use of routine screening measures by health care providers.

#### ***GOAL 4***

### ***Promote Federal, State, and Local Governmental and Private Agency Collaboration In Efforts to Prevent Family and Intimate Partner Violence***

#### ***ACTIONS***

- A. Establish a mechanism to initiate discussions and forge partnerships with other agencies within the U.S. Department of Health and Human Services and with the U.S. Departments of Defense, Education, and Justice to jointly fund family and intimate partner violence collaborative initiatives, and use current communications technology to highlight and promote model violence prevention programs.
- B. Establish mechanisms to involve foundations and corporations in inter-agency discussions on collaborative funding initiatives.
- C. Utilize funding priorities to foster collaboration among local governments, community-based organizations, and other local entities (e.g., civic organizations, the military, and the business and faith communities) in all HRSA grant-funded programs to prevent family and intimate partner violence. To ensure broad community collaboration, develop a common definition of “community” for use in program guidances to include cultural groups, indigenous populations, the workplace, grassroots organizations, military bases, and consumers. Require documentation of experiences and results from these collaborative initiatives through program evaluations and reports.
- D. Form a multidisciplinary and multi-cultural work group, with members selected from the roster of National Invitational Meeting participants, to study the consequences of welfare reform on victims of family and intimate partner violence and provide feedback to HRSA and other Federal agencies.
- E. Engage managed care industry leaders in discussions about family and intimate partner violence, its impact on physical and mental health, and how the problem can be prevented and treated through HRSA and health maintenance organizations (HMO).
- F. Support joint publications between the U.S. Department of Health and Human Services and other Federal agencies of resource materials on community-based solutions to family and intimate partner violence.
- G. Create and maintain, under the HRSA web site, a family and intimate partner violence prevention web site. Post descriptions of successful models of professional training and education, service delivery, family education, and research and evaluation.

***GOAL 5***

***Advance the Use of Standardized Definitions of Family and Intimate Partner Violence Within HRSA***

***ACTIONS***

- A. Provide training to HRSA Bureau and Office staff (e.g., through the HRSA Colloquia Series) on family and intimate partner violence that results in a shared understanding of the problem, who it affects, and how it is manifested in behaviors.
  
  - B. Develop operational definitions of family and intimate partner violence along the lines of those developed by the Centers for Disease Control and Prevention and the Agency for Health Care Policy and Research. Ensure that HRSA staff and grantees apply the operational definitions to the collection of data.
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## ***II. TRAINING***

## ***II. TRAINING***

Competency in identifying, treating, and preventing family and intimate partner violence is strongly tied to professional training. Used herein, training refers to the complete range of knowledge and skill-building opportunities for health care providers, spanning from undergraduate/graduate education courses to continuing professional development programs. Health care providers, as defined herein, include university/college faculty involved in health professions training, program administrators, and primary care providers (e.g., physicians, dentists, nurses, midwives, medical social workers, and so on.) This section addresses three education and training issues surrounding the development of a competent health care workforce. Specifically: (1) there is a need to equip health care providers with knowledge and skills specific to family and intimate partner violence prevention; (2) interdisciplinary collaboration is needed to make professional education and training relevant, effective, and accessible; and (3) community involvement is crucial to shape, provide, and evaluate professional education and training programs that are responsive to the uniqueness of each community's populations, needs, and resources.

### ***GOAL 1***

#### ***Improve and Expand Family and Intimate Partner Violence Education and Training for Health Care Providers***

#### ***ACTIONS***

- A. Provide support through grant and/or cooperative agreement mechanisms for HRSA-funded education and training centers to utilize distance learning technologies in promoting education and training on family and intimate partner violence. Strengthen the capacity of the education and training centers by providing an inventory of training and educational resources (e.g., Harvard School of Public Health's *National Trainer's Database*, and *National Directory of Violence Prevention Programs*).
- B. Explore options for establishing Interdisciplinary Centers of Excellence to serve as model training programs on family and intimate partner violence.
- C. Create an integrated approach within HRSA to identify and enhance the availability (through the use of HRSA's family and intimate partner violence web site, national clearinghouses, and resource centers, etc.) of curriculum resources that promote cultural competency, mental health, collaboration, universal use of routine screening, and standardized operational definitions and protocols in the delivery of family and intimate partner violence prevention services.
- D. Facilitate academic-community partnerships to ensure inclusiveness of community populations and their specific concerns in the design and delivery of training relevant to family and intimate partner violence.

- E. Facilitate the expansion of train-the-trainer programs to promote knowledge of the clinical aspects of family and intimate partner violence. Utilize mechanisms to provide technical assistance to communities on developing a core group of such clinically-skilled trainers.
- F. Support the development of scholars dedicated to advancing knowledge about the prevention of family and intimate partner violence by: (1) incorporating relevant curricula into current HRSA-funded fellowship programs; and/or (2) establishing a distinct HRSA fellowship program in the field of family and intimate partner violence prevention.

## ***GOAL 2***

### ***Develop Mechanisms for Collaboration to Address Family and Intimate Partner Violence Education and Training Issues***

#### ***ACTIONS***

- A. Ensure web site linkages between HRSA and current and potential partners to strengthen and/or foster collaboration in training and education (e.g., Harvard School of Public Health's proposed Internet on-line services for violence prevention specialists).
- B. Develop mechanisms for involving community-based "Family and Intimate Partner Violence Coordinating Councils" or similar collaborative entities in the design and implementation of HRSA-funded education and training programs.
- C. Pursue collaborative partnerships to utilize communications technologies, such as satellite teleconferences, for professional conferences and other types of education and training activities.
- D. Participate in jointly-funded family and intimate partner violence prevention training programs, such as the Harvard/Education Development Center Advanced Violence Prevention Training Program (now receiving joint funding from the HRSA Maternal and Child Health Bureau and the U.S. Department of Education's Safe and Drug Free Schools Program).

## ***GOAL 3***

***Promote Cultural Competency as an Overarching Principle in HRSA-Funded Family and Intimate Partner Violence Education and Training Programs***

***ACTIONS***

- A. Facilitate through funding mechanisms the incorporation of culturally competent practices into family and intimate partner violence prevention training curricula and the teaching activities of HRSA grantees. For example:
- 1) Utilize focus groups, with participants representing the community's populations and consumers, to help define community needs for training programs;
  - 2) Make use of advisory boards or similar entities, with members representing the community's populations, to advise the program on curricula design, development, implementation, monitoring, and evaluation;
  - 3) Involve educators and trainers who are reflective of the community in training programs; and/or
  - 4) Implement training programs that reach out to and target representative members of the community.
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### ***III. SERVICE DELIVERY***

### ***III. SERVICE DELIVERY***

HRSA, with its national network of primary care services for disadvantaged and underserved populations, is in a pivotal position to help communities develop a continuum of care that stretches from providing families with violence prevention information and skills to responding effectively to the diverse needs of victims. This section charts HRSA's course to make improved access and a continuum of care a reality in all communities, while addressing several issues: (1) fragmented community services; (2) increasingly complex family situations characterized by overlapping problems of partner abuse, child abuse, substance abuse, and unemployment; (3) barriers to accessible and acceptable services due to the lack of culturally appropriate service delivery systems, the need for universal and routine use of screening measures, and gaps in critical service components (such as the lack of shelters for battered women with older children or insufficient efforts to engage men in prevention and treatment efforts); (4) few opportunities for health care providers to learn about and replicate model service delivery programs; and (5) inadequate funding for services.

#### ***GOAL 1***

#### ***Promote a Coordinated, Collaborative Approach to the Management and Prevention of Family and Intimate Partner Violence***

#### ***ACTIONS***

- A. Through funding mechanisms, provide incentives for HRSA grantees to establish, or become part of, their community's "Family and Intimate Partner Violence Coordinating Council" or similar service coordination entity, to: (1) bring together the provider community; (2) identify available community services; and (3) inform both providers and consumers of the availability of community services and how to access them.
- B. Establish mechanisms to collect model collaborative and culturally appropriate protocols on family and intimate partner violence identification, assessment, and intervention. Utilize the HRSA web site for posting protocols, and/or provide collected models to national clearinghouses and resource centers for dissemination to the provider community. Draw on protocols from national, State, and local organizations, including private for-profit and non-profit organizations, voluntary and professional organizations, model programs, and academic and medical institutions.
- C. Sponsor conferences and meetings for HRSA-funded health care providers to:  
(1) share successful team approaches/models in the treatment and intervention of family and intimate partner violence; and (2) provide technical assistance on building collaborative treatment and intervention approaches.

- D. Provide incentives for HRSA grantees to recruit community leaders in the prevention of family and intimate partner violence (including individuals from diverse cultural and ethnic populations, underserved communities, and managed care organizations) for membership on their advisory boards.

## ***GOAL 2***

### ***Improve Access to Appropriate and Effective Family and Intimate Partner Violence Prevention and Treatment Services***

#### ***ACTIONS***

- A. Facilitate the universal use of routine family and intimate partner violence screening measures among HRSA-funded service providers. For example:
  - 1) Establish mechanisms to collect culturally appropriate screening models; and
  - 2) Disseminate the models through national clearinghouses and resource centers, or post them on the HRSA web site.
- B. Provide technical assistance/training to HRSA-funded health care providers on: (1) the etiology and symptoms of family and intimate partner violence; (2) when and how to use screening measures or how to adapt them to the community's populations; and/or (3) when and how to use community resources to confirm/rule out a diagnosis of family and intimate partner violence.
- C. Evaluate the effectiveness of the universal use of routine screening measures among HRSA-funded programs. For example:
  - 1) Require that HRSA grantees report on their progress in screening patients for family and intimate partner violence; and/or
  - 2) Fund community-based demonstration projects to evaluate the effectiveness of routine screening measures.
- D. Provide incentives for HRSA-funded health care providers to make available to all patients culturally appropriate educational materials on family and intimate partner violence, including information on safety planning and referrals for services/resources in the community. Make educational materials available in waiting rooms of maternal and child health clinics, well-baby clinics, hospitals, health care providers' offices, etc.

- E. Provide technical assistance/training to HRSA-funded health care providers on how to: (1) approach patients about family and intimate partner violence and make appropriate referrals to community services; (2) reach underserved populations in their communities (e.g., through outreach or home-based services, the faith/religious community, and other “non-traditional” approaches); and (3) increase competency in the delivery of services to diverse patient populations.
- F. Provide funding to assist underserved communities (migrant farm workers, isolated rural communities, inner-cities, American Indian reservations, and so on) develop their own outreach plans and referral strategies on family and intimate partner violence.
- G. Establish mechanisms to ensure that HRSA-funded health care programs incorporate cultural competency principles into their practices, including a diverse, multi-lingual staff reflective of the client population, the delivery of care within a cultural context, and the use of culturally-based screening tools and patient information materials.
- H. Convene a working group (composed of shelter providers, health care service providers, and health professions association representatives) to explore the feasibility of developing “one-stop shopping” program models to deliver integrated family violence intervention services.

### ***GOAL 3***

#### ***Maximize Funding Sources to Support Services for the Prevention and Treatment of Family and Intimate Partner Violence***

#### ***ACTIONS***

- A. Work cooperatively with other Federal agencies, State and local governments, and the private sector to identify new revenue sources for family and intimate partner violence prevention initiatives. For example:
  - 1) Engage other Federal agencies in exploring joint funding opportunities for prevention services; and/or
  - 2) Convene State and community forums for providers and public/private program funders to: (a) examine gaps in services; (b) increase awareness about family and intimate partner violence; and (c) explore opportunities for public/private partnerships.

- B. Analyze funding mandates to identify opportunities to replicate and/or expand successful programs that provide family-oriented primary prevention health care services for abused and battered persons. Make use of national clearinghouses, resource centers, and other sources to select successful programs.
- C. Facilitate technical assistance and training for HRSA grantees to aid in building relationships with advocacy groups in order to influence legislation that supports service delivery programs for victims of family and intimate partner violence.
- D. Explore ways to integrate screening and intervention activities for family and intimate partner violence into HRSA grant programs for primary health care.
- E. Work with the Health Care Financing Administration to examine the feasibility of using Medicare and Medicaid funds to offset the costs associated with family and intimate partner violence screening activities and interventions.
- F. Convene a workgroup within HRSA to study the feasibility of implementing a single grant application for treatment and prevention services.
- G. Increase awareness among community groups on funding possibilities for prevention and treatment services. For example:
  - 1) Create and maintain, on the HRSA web site, a listing of grant programs that provide funding for prevention and treatment services; and/or
  - 2) Establish mechanisms to provide technical assistance to community-based service providers on grant writing and developing creative collaborative approaches to securing funds.



***IV. FAMILY EDUCATION AND PREVENTION  
PROMOTION***

## ***IV. FAMILY EDUCATION AND PREVENTION PROMOTION***

Awareness and knowledge of family and intimate partner violence is crucial to build a strong base of public support for prevention. This section spells out a leadership role for HRSA in bringing violence prevention education to individuals, families, and communities by addressing four interrelated issues: (1) the need to increase awareness of family and intimate partner violence among the general population; (2) a lack of responsiveness in family and community education to the cultural variables surrounding violence; (3) misperceptions of family and intimate partner violence due to prevailing attitudes and beliefs, or seeing violence as someone else's problem; and (4) gaps in community ownership of prevention education programs and campaigns by the media, businesses, civic leaders, elected officials, and representatives of the community's cultural populations.

### ***GOAL 1***

#### ***Increase Awareness of Family and Intimate Partner Violence Among Families and Communities***

#### ***ACTIONS***

- A. Take a leadership role in planning and implementing a national public health campaign to stop family and intimate partner violence that: (1) is based upon standard marketing research of different target audiences; (2) offers unified and culturally appropriate "stop violence" messages to the different target audiences; and (3) encompasses a variety of approaches, such as television spots, public service announcements, and print materials.
- B. Foster information dissemination by supporting, contributing to, and promoting national clearinghouses and resource centers concerned with the prevention of family and intimate partner violence. For example:
  - 1) Identify and allocate funds toward the operation of the clearinghouses and resource centers;
  - 2) Provide resource materials and descriptions of model programs on family and intimate partner violence prevention for dissemination to communities; and/or
  - 3) Increase HRSA constituents' knowledge of and access to these national clearinghouses and resource centers.
- C. Establish mechanisms to endorse a full continuum of opportunities for families to develop parenting, care giving, stress management, and life skills (e.g., Mississippi statute mandating parenting classes in all junior high schools; Bienestar Family Service Project in Sunnyside, Washington; AVANCE Family Support and Education Program in San Antonio, Texas; and Mujeres Latinas en Accion in Chicago, Illinois).

- D. Establish mechanisms to utilize survivors as advocates and disseminators of information about family and intimate partner violence, including facts regarding the magnitude of the problem and protective/preventive strategies.

## ***GOAL 2***

### ***Ensure the Development and Promotion of Culturally Appropriate Family and Community Education Programs***

#### ***ACTIONS***

- A. Establish mechanisms to empower communities to conduct needs assessments, and develop, implement, and evaluate family-focused family and intimate partner violence prevention educational programs and campaigns to ensure that cultural variables are incorporated into programs. For example:
  - 1) Provide technical assistance to communities on the needs assessment process and on program development, implementation, or evaluation; and/or
  - 2) Through funding incentives, foster the development of local advisory groups (representative of HRSA-funded programs, community grassroots organizations, non-traditional partners, and violence survivors) to assist in identifying family and community education needs, gaps, and barriers, and to develop responsive education program strategies.
- B. Involve persons with relevant cultural and ethnic backgrounds in the development of culturally appropriate family and community educational materials that address family and intimate partner violence across the life cycle stages (i.e., prenatal development, infancy, early childhood, childhood, adolescence, adulthood, and older adulthood). Identify points of entry at each life cycle stage (i.e., maternal and child health programs, child care and school health programs, public housing complexes, health care service providers, the workplace, colleges, churches, sports and recreation programs, and senior citizen programs) for dissemination of materials. Materials should be culturally responsive and multi-lingual.
- C. Facilitate collaboration among other health entities, State and local social and judicial systems, community-based organizations, and educational systems to help customize culturally relevant programs and intervention strategies for specific communities and settings.
- D. Research and gather culturally appropriate materials and descriptions of model programs and provide to national clearinghouses and resource centers for dissemination.

## ***GOAL 3***

***Promote Public Support for Making the Prevention of Family and Intimate Partner Violence Everyone's Responsibility***

***ACTIONS***

- A. Facilitate, through funding opportunities, partnerships among national groups, community organizations, and non-traditional partners to gain support for educational initiatives in family and intimate partner violence prevention. Give priority to grant applicants that demonstrate collaboration with non-traditional partners, such as the Rotary Club, the Kiwanis, the Boy Scouts, the Girl Scouts, the Older Women's League, the religious community, elementary and secondary schools, the corporate sector, sports organizations, and the criminal and juvenile justice systems.
- B. Identify and allocate funding for the design and evaluation of pilot demonstration projects on male involvement in family and intimate partner violence prevention. Disseminate findings on effective models to the communities.
- C. Facilitate the development and dissemination of educational materials in forms suitable for different audiences (i.e., legislators, policy makers, community leaders, and the media) and applicable to local jurisdictions, to enable the members of these audiences to become advocates for local initiatives on family and intimate partner violence prevention.
- D. Make available on HRSA's web site descriptions of: (1) model community violence prevention campaigns, including those demonstrating non-traditional community partnerships and the education of legislators, policy makers, community leaders, and the media; (2) national clearinghouses and resource centers offering information that will assist in the development of collaborative violence prevention campaigns; and (3) national family and intimate partner violence reporting and referral hotlines.
- E. Support community-based education programs that train youth, adult, and elder survivors, as well as other individuals, to become leaders in family and intimate partner violence prevention education and advocacy.
- F. Establish a mechanism of community-based outreach to ensure that all women have access to educational materials that enable them to protect themselves from being a victim of family and intimate partner violence.



## ***V. RESEARCH AND EVALUATION***

## ***V. RESEARCH AND EVALUATION***

HRSA leadership in research and evaluation of family and intimate partner violence would facilitate a coordinated, systematic, and planned research and evaluation agenda, with Federal agencies joining forces to improve the quality and quantity of violence-focused research. HRSA programs can strengthen and expand the knowledge base of family and intimate partner violence by closing three critical gaps in research on: (1) populations that have not been included or singled out in family and intimate partner violence research, which often overlap with the populations that HRSA serves; (2) the interaction between cultural variables and family and intimate partner violence; and (3) factors that pose risk of, or offer protection from, family and intimate partner violence. HRSA can meet another critical need by creating viable interfaces between the research community and policy makers, program administrators, educators, and health care providers in order to apply research and evaluation findings to professional training, family education, service delivery, and policy development.

### ***GOAL 1***

#### ***Foster Collaborative Multidisciplinary Approaches to Research Related to the Prevention of Family and Intimate Partner Violence***

### ***ACTIONS***

- A. Establish an Agency-wide research working group to establish research and evaluation priorities in family and intimate partner violence. The workgroup will interact with Bureaus and Offices to identify promising and critical areas for research and explore funding strategies.
  
- B. Explore collaborative research possibilities with potential partners such as the Federal Inter-Agency Task Force on Child Abuse and Neglect, the Advisory Council on Violence Against Women, other agencies within the U.S. Department of Health and Human Services (e.g., the Centers for Disease Control and Prevention, the Health Care Financing Administration, the National Institutes of Health, the Agency for Health Care Policy and Research, the Administration for Children and Families, the Administration on Aging, Indian Health Services, and the Substance Abuse and Mental Health Services Administration), and other Federal agencies. For example, hold meetings and forums to develop an inter-agency task force or similar entity to examine substantive issues related to the funding, design, and conduct of collaborative research and evaluation projects on family and intimate partner violence.

## ***GOAL 2***

### ***Support Research to Expand Knowledge about the Prevention of Family and Intimate Partner Violence in Populations Served by HRSA***

#### ***ACTIONS***

- A. Provide funding to support research and evaluation studies to close gaps in knowledge about HRSA-served populations, including but not limited to the formerly incarcerated, the very poor, immigrants, the disabled, the aged, and the perpetrator. For example:
- 1) Request that national clearinghouses and resource centers conduct searches for population-specific data related to family and intimate partner violence;
  - 2) Request from HRSA grantees information on the composition and characteristics of the populations they serve, including data on family and intimate partner violence experiences;
  - 3) Establish mechanisms to assess the current state of knowledge of the populations served by HRSA, including the prevalence and incidence of violence, socio-economic and demographic characteristics, help-seeking behaviors, and the utilization of health care resources; and/or
  - 4) Forge research funding partnerships with foundations, corporations, and Federal agencies serving the same populations as HRSA.

## ***GOAL 3***

### ***Promote Research to Identify Risk and Protective Factors Related to Family and Intimate Partner Violence, Including Resiliency, Psychosocial, Predisposing, and Environmental Factors***

#### ***ACTIONS***

- A. Support research to determine risk and protective factors in populations served by HRSA. For example:
- 1) Request that national clearinghouses and resource centers conduct searches for data on risk and protective factors and identify other sources of information on these factors (e.g., research projects underway and unpublished papers);
  - 2) Meet with staff from the U.S. Department of Justice (DOJ) to learn more about DOJ's studies on risk and protective factors; and

- 3) Support projects that validate and establish the reliability and predictability of current risk assessment instruments.

#### ***GOAL 4***

#### ***Support Research Studies That Examine the Influence of Culture on Family and Intimate Partner Violence to Facilitate the Development of Culturally Appropriate Interventions***

#### ***ACTIONS***

- A. Fund projects to assess available qualitative and quantitative data on the influence of culture on family and intimate partner violence.
- B. Make use of a family and intimate partner violence prevention advisory group comprised of specialists from diverse cultural and ethnic populations to: (1) identify and facilitate the use of culturally acceptable data collection tools in HRSA-funded studies; and (2) design and plan research and evaluation programs.
- C. Fund research to study the causes, effects, and identification of family and intimate partner violence and the effectiveness of prevention and treatment in populations served by HRSA.
- D. Fund evaluation projects to assess the effectiveness of different types of non-traditional culturally based interventions on the reduction of family and intimate partner violence.
- E. Require HRSA-funded studies related to family and intimate partner violence to include culture or ethnicity as a variable in research.

#### ***GOAL 5***

#### ***Support Evaluation Studies Related to Family and Intimate Partner Violence That Promote the Use of Multiple and Clearly Defined Outcome Measures***

#### ***ACTIONS***

- A. Support an outcome-based research agenda to address such issues as: (1) the screening and identification of victims and abusers in health care settings; (2) the prevalence and incidence of violence in populations served by HRSA; (3) culturally acceptable assessment tools and intervention strategies; (4) the history or cycle of violence in families; (5) violence outcomes for help seekers versus non-help seekers; (6) the workforce and health care costs of violence; (7) the costs and benefits of intervention versus non-intervention by health care providers; and (8) risk, protective, and cultural factors influencing prevention outcomes. Outcome data should reflect race/ethnic and subgroup differences.

- B. Incorporate into Requests for Proposals requirements for: (1) quantitative and qualitative research; (2) sufficient time parameters to produce meaningful and conclusive findings; (3) multi-site studies, as appropriate; and (4) an evaluation component in demonstration service delivery projects, along with the provision of technical assistance on the evaluation component.

### ***GOAL 6***

#### ***Encourage Improvement in the Delivery of HRSA-Funded Services Through Application of Research and Evaluation Findings***

#### ***ACTIONS***

- A. Establish mechanisms to translate research and evaluation study findings into clinical and/or training applications and research-based instruments wherever possible. Incorporate study findings into: (1) health care standards relevant to family and intimate partner violence prevention and intervention; (2) screening measures; (3) training curricula; and (4) research-based instruments for assessing risk and protective factors in individuals, families, and communities.
  - B. Utilize a variety of vehicles to inform HRSA grantees and other constituents of research and evaluation study findings and practice implications, including:
    - (1) national clearinghouses and resource centers; (2) the HRSA web site; and
    - (3) conferences and forums.
  - C. Provide technical assistance to HRSA-funded health care service providers on: (1) the applicability of family and intimate partner violence research and evaluation study findings to the grantee's community and service populations; (2) ways to incorporate revised health care standards and violence screening measures into service delivery practices; and (3) evaluating service delivery practices based on the use of revised health care standards and violence screening measures.
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***APPENDIX A***

***ACTION PLAN DEVELOPMENT PROCESS***

## ***ACTION PLAN DEVELOPMENT PROCESS***

The Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, has recognized family and intimate partner violence as a major public health concern for more than a decade. In 1995, that concern was sharpened when HRSA launched the **National Family and Intimate Partner Violence Prevention Initiative**. A Steering Committee for the Initiative was formed under the leadership of the Office of Minority Health, with all four HRSA Bureaus—Bureau of Health Professions, Bureau of Health Resources Development, Bureau of Primary Health Care, and Maternal and Child Health Bureau—represented by Committee members. A list of Steering Committee members is presented at the end of this Appendix. One of the major Committee tasks was to plan for the National Invitational Meeting on Prevention of Family and Intimate Partner Violence, a meeting that would bring approximately 100 key advisors together to contribute to the Action Plan's development. The strategic planning and action plan development process is discussed below and depicted in the pictorial chart on the following page.

### ***Planning Committee Meeting***

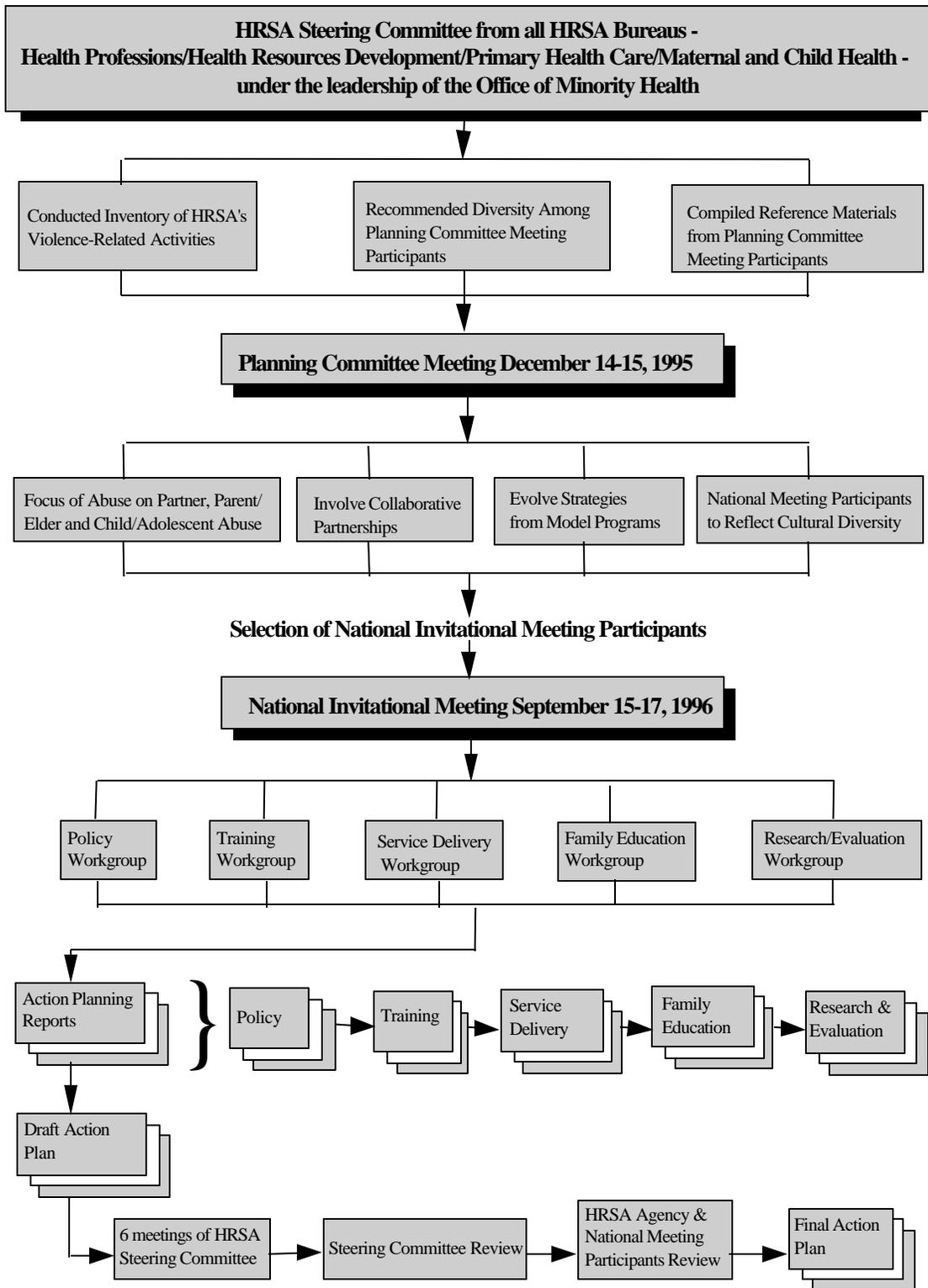
In line with the collaborative thrust of the Initiative, the Steering Committee recommended the involvement of a cross-section of organizations, programs, and disciplines in the development of the Planning Committee and the planning of the National Invitational Meeting. To acquaint the Planning Committee with ongoing programs within HRSA, the Steering Committee provided oversight in conducting an inventory of HRSA's family and intimate violence prevention related activities. The Steering Committee also recommended diversity in professional backgrounds and cultural experiences among Planning Committee Meeting participants. Once identification and recruitment of Planning Committee Meeting participants was completed, reference materials were requested from these individuals. These materials later served as resources during the Planning Committee Meeting.

The Planning Committee Meeting was held on December 14 - 15, 1995, in Washington, D.C., with 30 participants in attendance, representing academia, national and local foundations, community-based organizations, the religious community, health organizations, and Federal agencies. Highlighted among the recommendations made during the Planning Committee Meeting that gave shape to the National Invitational Meeting and, in turn, to the HRSA *Action Plan to Prevent Family and Intimate Partner Violence*, were:

- C Focus family and intimate partner violence in terms of partner abuse, parent/elder abuse, and child/adolescent abuse, and define violence to include a broad range of destructive, violent, and neglectful behaviors (please refer to *The Scope of Family and Intimate Partner Violence* chart in the *Introduction* section). Define "family" and "intimate" broadly and inclusively, so that violence in non-traditional family units, as

# Strategic Planning and Action Plan Development Process

## National Family and Intimate Partner Violence Prevention Initiative



well as violence occurring between same-sex intimate partners, would be subsumed in the Action Plan's violence prevention strategies.

- C Within the Action Plan's framework, provide for the identification and establishment of collaborative partnerships with other Federal agencies, State and local governments, as well as national professional and advocacy organizations, foundations, businesses and corporations, community-based violence prevention programs, and grassroots organizations.
- C Define "model" as a program or approach that works in preventing family and intimate violence. Utilize model programs at the National Invitational Meeting as a vehicle to demonstrate to participants successful programs and strategies. The resulting Action Plan should reflect strategies evolved from model programs or approaches and should set realistic goals and strategies consistent with HRSA's mission.
- C Select participants for the National Invitational Meeting who collectively represent diverse cultures and knowledge of abuse within the recommended family life cycle stages of partner, parent/elder, and child/adolescent. Likewise, select participants from diverse professional backgrounds at the Federal, State, and community levels and from a variety of disciplines.

### ***National Invitational Meeting on Prevention of Family and Intimate Partner Violence***

National Invitational Meeting participants were identified and recruited based on the Planning Committee's recommendation for a participant base comprised of individuals from diverse cultural and professional backgrounds. The National Invitational Meeting, held September 15 - 17, 1996, in Washington, D.C., was guided by three objectives: (1) to examine existing models of violence prevention that have realized success in their respective communities; (2) to identify critical areas of collaboration—between HRSA and community-based programs, national organizations, foundations, and corporations—as related to family and intimate partner violence prevention; and (3) to develop an Action Plan (which builds upon successful violence prevention models) to assist HRSA in implementing a coordinated Agency-wide response to family and intimate partner violence.

To achieve the National Invitational Meeting's objectives, the Meeting's approach had four major components: (1) broad participant representation; (2) active participant involvement, including roles as model program presenters, workgroup facilitators, and workgroup members; (3) a structured action planning process; and (4) focused workgroups organized into five action planning tracks: policy; training; service delivery; family education and prevention promotion; and research and evaluation.

Across workgroups, participants included specialists in partner abuse, parent/elder abuse, and child/adolescent abuse, and a mix of HRSA, model program, State and local public agency, and business, national organization, and foundation representatives, as well as cultural diversity. Representatives from six model programs presented information on their effective strategies during the National Invitational Meeting (please refer to *Appendix E., Selected National Invitational Meeting Materials, Section A* for descriptions of these six model programs). Using a structured action planning process and, specifically, an Action Planning Worksheet as a guide, each workgroup developed an Action Planning Report specific to their assigned track topic. Once completed, a spokesperson from each of the five workgroups shared their Action Planning Reports in a general session to obtain feedback from all National Invitational Meeting participants. Revisions to the Action Planning Reports were made accordingly.

### ***Preparation of HRSA Action Plan to Prevent Family and Intimate Partner Violence***

October 1996 marked the beginning of a series of meetings of the HRSA Steering Committee and the Office of Minority Health to review the Action Planning Reports generated during the National Invitational Meeting and to refine and further synthesize them into a draft Action Plan. The *Action Plan to Prevent Family and Intimate Partner Violence* presents a chapter for each of the five National Invitational Meeting workgroup areas—Policy, Training, Service Delivery, Family Education and Prevention Promotion, and Research and Evaluation. Each chapter presents goals and related, achievable, stand alone actions. The draft Action Plan was reviewed by the HRSA Steering Committee and the Agency, as well as the National Invitational Meeting participants, before being finalized.

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## ***APPENDIX B***

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***APPENDIX D***

***SUGGESTED EDUCATIONAL RESOURCES***

## ***SUGGESTED EDUCATIONAL RESOURCES***

*A Community Checklist: Important Steps To End Violence Against Women “...what can we do about it?”*

U.S. Department of Health and Human Services and U.S. Department of Justice  
Contact: Office on Violence Against Women  
U.S. Department of Justice  
Telephone: 202-616-8894

*Adolescent Maltreatment Technical Information Bulletin*

Contact: National Maternal and Child Health Clearinghouse  
Telephone: 703-821-8955, ext. 5

*AVANCE Parenting Education Curriculum*

Contact: Carmen P. Cortez, M.A.  
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*CommuniKit (Workplace Education)*

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Elder Abuse Documents:

- 1) *Domestic Maltreatment of the Elderly, Toward Prevention*
- 2) *Spouse/Partner Abuse in Later Life, Resource Guide for Service Providers*
- 3) *Toward the Prevention of Domestic Mistreatment or Abuse, A Training Course*

Contact: Criminal Justice Services  
American Association of Retired Persons  
601 E Street, NW  
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Telephone: 202-434-2222

*Elder Abuse: Questions and Answers. An Information Guide for Professionals and Concerned Citizens.*

Contact: National Center on Elder Abuse  
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Contact: Sage Publications, Inc.

P.O. Box 5084

Thousand Oaks, California 91359

Telephone: 805-499-9774

Health Professionals Materials:

- 1) *Improving the Health Care Response to Domestic Violence*
- 2) *General Information Packet*
- 3) *Primary Care Packet*
- 4) *Emergency Department Packet*
- 5) *Screening Patients for Domestic Violence*
- 6) *Mandatory Reporting Discussion Paper*
- 7) *Sample Domestic Violence Protocols*
- 8) *Practitioner Reference Cards*
- 9) *Safety Information Card*

Contact: Health Resource Center on Domestic Violence

Family Violence Prevention Fund

383 Rhode Island Street, Suite 304

San Francisco, California 94103

Telephone: 415-252-8900

*Improving the Response to Domestic Violence: Recommendations to Federal Agencies*

Schechter, Susan.

Contract: Centers for Disease Control and Prevention

Telephone: 770-488-4410

*Looking for a Better Road—The Farmworker Women's Domestic Violence Training Project—  
1995 Year End Report*

Contact: Karen Mountain, M.B.A., M.S.N., R.N.

Chief Executive Director

Migrant Clinicians Network

P.O. Box 164285

Austin, Texas 78716

Telephone: 512-327-2017

*Non-Violent Parenting Training Manual*

Contact: Montgomery County Abused Persons Program

4905 Del Ray Avenue, Suite 200

Bethesda, Maryland

Telephone: 301-986-5885

*Nunca Mas—Never Again* (Docudrama on Violence with Guide)

Contact: Berta Hinojosa

Coordinator, Domestic Violence and Sexual Assault Programs

Mujeres Latinas en Accion

1823 West 17th Street

Chicago, Illinois 60608

Telephone: 312-226-1544

Parenting Education and Paraprofessional Staff Training Materials:

- 1) *Prenatal Curriculum*
- 2) *Healthy Start Manual*
- 3) *A Dance with Your Baby*
- 4) *Parent and Baby Play Book*
- 5) *Infant/Toddler Training Curriculum*
- 6) *A Rhythm of Our Own*
- 7) *Parent-Child Activities, 3-5 Years*

Contact: Gladys Wong

Community and Family Support Services/Healthy Start

2881 Waimano Home Road

Pearl City, Hawaii 96782

Telephone: 808-453-6020

Facsimile: 808-453-6023

Reports from the U.S. Advisory Board on Child Abuse and Neglect:

- 1) *A Nation's Shame: Fatal Child Abuse and Neglect in the United States.* 1995
- 2) *Neighbors Helping Neighbors: A New Strategy for the Protection of Children.* 1993
- 3) *Creating Caring Communities: Blueprint for Effective Federal Policy on Child Abuse and Neglect.* 1991

Contact: National Clearinghouse on Child Abuse and Neglect Information

P.O. Box 1182

Washington, DC 20013-1182

Telephone: 800-FYI-3366

Facsimile: 703-385-3206

*Serving the Older Battered Woman*

Contact: San Francisco Consortium for Elder Abuse Prevention

Goldman Institute on Aging

3330 Geary Boulevard

San Francisco, California 94118

Telephone: 415-750-4188

*Together We Can—A Guide for Crafting a Profamily System of Education and Human Services*

U.S. Department of Education and U.S. Department of Health and Human Services

Contact: U.S. Government Printing Office

Superintendent of Documents

Mail Stop SSOP

Washington, DC 20402-9328

Violence-Related Articles on Women and Children:

- 1) Browne, A. 1993. "Violence Against Women by Male Partners." *American Psychologist* (October 1993).
- 2) Browne, A. Fall 1995. "Reshaping the Rhetoric: The Nexus of Violence, Poverty, and Minority Status in the Lives of Women and Children in the United States." *Georgetown Journal on Fighting Poverty* (Vol. 3): No. 1.

Contact: Angela Browne, Ph.D., Assistant Director of Research/Research Scientist

Better Homes Foundation

181 Wells Avenue

Newton, Massachusetts 02159

Telephone: 617-964-3834

*Violence and Teen Pregnancy* (Resource Guide)

Contact: Michelle Stober

Children's Safety Network

Education Development Center

Telephone: 617-969-7100

WomanKind Program Information:

Hadley, Susan M.; Short, Lynn M.; Lezin, Nicole; and Zook, Eric. Winter 1995. "WomanKind: An Innovative Model of Health Care Response to Domestic Violence."

*Women's Health Issues* (Vol. 5): No. 4.

Contact: Susan Hadley, M.P.H., Founder and Director

WomanKind: Support Systems for Battered Women

Fairview Health System

6401 France Avenue South

Minneapolis, Minnesota 55435

Telephone: 612-924-5775

*Women's Health Protocol: Violence/Abuse/Battering*

Contact: Joan Clayton, Assistant Director of Nursing  
San Antonio Metropolitan Health District  
332 West Commerce  
San Antonio, Texas 78205  
Telephone: 210-207-8808

*ZERO to THREE* Bulletin, June/July 1996. (Parent Groups)

Contact: Publications Department, ZERO to THREE  
Telephone: 202-638-0840 or 800-899-4301

*Massachusetts Medical Society Seminar Series on Domestic Violence.* Four-part curriculum for medical professionals in 3-ring binder. Includes text, handouts, slides, video, CD-ROM, and teaching guide.

Contact: Susan Webb, Director, Public Health Services  
Massachusetts Medical Society  
1440 Main Street  
Waltham, Massachusetts 02154  
Telephone: 800-332-2303, ext. 1015  
E-Mail: dph@mms.org

*Diagnosis: Domestic Violence.* Videotape; Run Time 23:40.

Contact: Amy Seeherman  
Office of the Attorney General, Commonwealth of Massachusetts  
1 Ashburton Place  
Boston, Massachusetts 02108  
Telephone: 617-7272200, ext. 2553

*Understanding Partner Abuse.* CD-ROM. Three-disc set for health professional training.

Contact: David Doepel  
Echo Bridge Productions  
Telephone: 800-738-0786

The American College of Obstetricians and Gynecologists Information:

*Domestic violence: the Role of the Physician in Identification, Intervention, and Prevention.*

A slide lecture which contains 68 slides, instructional notes, and resource lists. It is a comprehensive overview of domestic violence that is suitable for a wide variety of audiences.

English and Spanish

Technical Bulletin #101, entitled *Sexual Assault*

Technical Bulletin #209, entitled *Domestic Violence*

Rolodex cards - featuring screening questions and National Domestic Violence toll free hotline numbers

Continuing education videos and monographs

Contact: Deborah L. Horan

Telephone: 202-863-2487

Facsimile: 202-484-3917

E-Mail: dhoran@acog.org

*Domestic Violence: How to Ask and What to Say* - Videotape

Contact: Health Partners

Telephone: 612-883-6745

*El Camino Hacia La Seguridad—Como Los Tribunales Pueden Ayudarle a Obtener Proteccion* (Journey to Safety—How Can Courts Help You Get Protection From Domestic Violence) - Videotapes

Contact: Montgomery County Abused Persons Program

4905 Del Ray Avenue, Suite 200

Bethesda, Maryland

Telephone: 301-986-5885, ext. 0

*Mujer Valorate* (Woman: Value Yourself) - Videotape

Contact: Hermanas Unidas, Ayuda, Inc.

1736 Columbia Road, NW

Washington, DC 20009

Telephone: 202-387-2870



*APPENDIX E*

*SELECTED NATIONAL INVITATIONAL MEETING  
MATERIALS*

## ***A. Descriptions of Model Programs Presented at the National Invitational Meeting***

### ***AVANCE Family Support and Education Program***

**Contact:** Ms. Carmen P. Cortez  
Vice President for Program Services and Development  
AVANCE, Inc.  
301 South Frio, Suite 310  
San Antonio, TX 78207  
Telephone: 210-270-4630 / Facsimile: 210-270-4612

**Program Type:** AVANCE Chapters provide direct family intervention through parent education, early childhood education, youth programs, social support systems, adult basic and higher education, and community development. Training and technical assistance services are available for a fee for other groups.

**Target Population:** Hispanic families with children under age three. Participating families are characterized by economic poverty.

**Setting:** Center-based, school-based, and mobile services to families in multiple locations in Texas. Training and technical assistance services are available on-site or in San Antonio.

**Program Description:** Established in 1973, AVANCE is one of the first family support and education programs in the U.S. and one of the first comprehensive, community-based, family support programs to target at-risk and Hispanic populations.

AVANCE goals are to strengthen families and prevent child abuse and neglect; conduct research on the conditions and factors associated with the social/economic problems of at-risk communities; evaluate the effectiveness of service delivery; and operate a National Training Center to disseminate information to service providers and policy makers interested in supporting at-risk Hispanic families. Programs conducted by AVANCE are:

- C Parent-Child Education Program: a nine-month parent education program serving families and their children age three and younger; parents learn about all aspects of child development, community services, and nutrition.
- C Even Start: a family-centered program focusing on family literacy and parent education in neighborhood elementary schools. Simultaneously involving parents and children, it enables parents to gain knowledge of and participate in the early learning of their children, increase school parental involvement, and to further their own education through AVANCE Adult Literacy Programs.
- C Adult Literacy and Higher Education: basic literacy, GED, English as a second language courses; as well as child care, transportation, referral, scholarship, placement, and registration assistance services.

- C Early Head Start Program: health and nutrition information, medical services, counseling, crisis intervention, adult literacy training, youth development and job skills training, job placement, housing assistance, and substance abuse treatment referrals. AVANCE graduates are provided appropriate opportunities for becoming employed outside the home or self-employed, an initiative that is contracted through collaboration with existing job training and placement services.
- C Child Abuse and Neglect Intervention: comprehensive in-home support and case management services for court-referred families. Through a direct intervention program, AVANCE offers comprehensive, community-based services to parents and children aimed at helping parents understand their roles, build up self-esteem, and help parents get out of the cycles of abuse.
- C Fatherhood and Couples Classes: a supporting component designed to enhance the parental role of the father and partnerships by providing parenting information, social support and positive social outlets.
- C Youth Development and Delinquency Prevention Program: youth activities, personal and social development classes, tutoring, scout programs, and recreational/enrichment activities.

Along with city, county, state, and Federal government sources, the AVANCE National Office is funded through multiple foundations, including:

Carnegie Foundation	W.K. Kellogg Foundation
Ford Foundation	Kraft Foundation
Foundation for Child Development	Meadows Foundation
Hasbro Children’s Foundation	Mott Foundation
Hilton Foundation	Rockefeller Foundation

During 1994-95, more than 6,000 adults and children received AVANCE services. AVANCE information has been disseminated in more than 40 states, curriculum has been sold in 15 states, and training has reached individuals from 24 states.

An extensive scientific evaluation funded by the Carnegie Corporation of New York has provided strong evidence supporting the program’s effectiveness. Two annual cohorts were followed for two years at two program sites. Control groups, randomly assigned at one site and matched at the second site, were also employed. Upon completion of the program and then again one year later, data was collected concerning maternal knowledge, behavior, attitudes, and continuing education. Among the findings on program effectiveness were:

- C AVANCE mothers were observed to be more positive in interacting with their children, provide a more organized and stimulating home environment, use more contingent praise with their children, and offer more encouragement of their children’s verbalizations;

- C AVANCE mothers reported more opposition to physical punishment, more nurturing attitudes toward their children, enhanced views of self as their children’s teacher, and increased knowledge and use of community resources; and
- C More AVANCE participants elected to continue their education: 57 percent of mothers who dropped out completed their GED; 64 percent of mothers who completed high school or their GED attended college or a technical program; 94 percent of children completed high school or their GED; and 43 percent of children were attending college.

***Bienestar Family Service Project***

**Contact:** Mr. Cristobal Gonzalez  
 Washington State Migrant Council  
 301 North First Street, Suite One  
 Sunnyside, WA 98944  
 Telephone: 509-837-8909 / Facsimile: 509-837-3424

**Program Type:** Family education and prevention promotion, service delivery.  
**Target Population:** Rural and minority (mostly Hispanic migrant/seasonal and American Indian) substance abusing parents and their children under age 18.  
**Setting:** Family Support Services and Residential Center in Yakima County, Washington.  
**Program Description:** The Washington State Migrant Council provides multiple services to rural and minority children and families in the lower Yakima Valley through its Family Support Services and Residential Center (FSSRC). Yakima County has a significantly large minority population, 44 percent of which is comprised of Hispanic and American Indian families. In addition to these groups, there are an estimated 50,000 Hispanic migrant/seasonal workers who are employed in the lower Yakima Valley region during harvest season. Many former migrants reside permanently in the region.

The overall goal of the Washington State Migrant Council’s Bienestar Family Service Project is to provide culturally relevant, emergency family support services to rural and minority families where the cycle of abuse is compounded by the adverse effects of drugs and alcohol. Included are referral services and bilingual public awareness information, education, and training to community service providers and the community. All services of the project are delivered in a culturally and linguistically appropriate manner to meet the needs of the target population. The Project’s residential center—the Bienestar Family Support Services and Residential Center—provides:

- C crisis and emergency residential care for children from 3-16 years of age, who have been or are at-risk of being abused and/or neglected as a result of adult substance abuse or other family crisis;

- C comprehensive case management services for parents to obtain skills that help them improve the quality of life for their families; and
- C community education on substance abuse, child abuse and neglect prevention and intervention resource capabilities.

The Residential Center, open 24 hours every day, is staffed by extensively trained house parents. Within the homelike environment, staff offer children/youth emotional support, a stable, secure living structure, and activities that encourage positive development. The case management component focuses on preventing abuse and neglect, offering parents information, counseling, and referrals. Respite care offers parents a brief period of time without their children to seek help for themselves. Other family support services include assessment, development of a family service plan, service linkages and coordination, emergency transportation, advocacy, mediation, information, and education. Staff commitment remains a hallmark of the project and is substantiated by positive feedback from participants.

To help families reduce the risk of child maltreatment due to substance abuse, the FSSRC project collaborates with numerous community agencies to provide crisis counseling, detoxification, chemical dependency assessment and treatment, and comprehensive aftercare services. Children of substance abusing parents benefit from family therapy, counseling, and education. In coordination with other Washington State Migrant Council components, the Bienestar Family Support Project spearheaded *WSMC's State Conference on Children, Youth, and Families* in 1995, which dedicated an entire strand to child abuse prevention and intervention in families. Project services are made possible by the U.S. Department of Health and Human Services' National Center on Child Abuse and Neglect (NCCAN). The project was originally funded for three years and received a 13-month continuation grant. The project has an internal evaluator who monitors and evaluates the impact and success of the Bienestar Project. Additionally, NCCAN has a technical assistance team that meets with staff and previous clients twice a year to collect data and develop findings.

### ***Domestic Violence Education Project***

**Contact:** Ms. Patricia A. Paluzzi

Domestic Violence Education Project

Special Projects Section

American College of Nurse-Midwives

818 Connecticut Avenue, NW, Suite 900

Washington, DC 20006

Telephone: 202-728-9863 / Facsimile: 202-728-9896 / Email: [ppaluzzi@acnm.org](mailto:ppaluzzi@acnm.org)

**Program Type:** A nationwide education project for women's health care providers, primarily Certified Nurse-Midwives (CNMs), on the issue of domestic violence, including assessment, clinical impact, intervention, and referral.

**Target Population:** Nurse-midwifery clinicians and educators.

**Setting:** Several training sessions have occurred in various regions of the United States.

**Program Description:** Funded by the Maternal Child Health Bureau of DHHS, this three-year education project began in October 1994. The primary goal is to promote universal screening for domestic violence among women presenting for midwifery care in the United States. The methodologies employed to meet this goal involve the topics of education, advocacy, networking, and sustainability.

- C** Education is two-fold with CEU-based activities for clinicians offered in four different regions as part of the standard American College of Nurse-Midwives (ACNM) model of Regional Workshops and as a pre-annual meeting training in Years 2 and 3. While the primary audience is nurse-midwives, registration was not restricted. Two Training-of-Trainers (TOTs) for midwifery educators were held with an emphasis on clinical skills and integration of the material into the curricula of midwifery schools.
- C** Materials developed to support the education include a domestic violence education module, which has been given to all participants of both the CEU-based trainings and the TOTs. A training curriculum for women's health care professionals was released in October of 1996. It includes a two-video presentation with a companion manual.
- C** Advocacy is included as a part of the curriculum for all trainings and discussed as an important aspect of addressing the issue. In addition, the Project Director, Advisory Board and Expert Consultants to the project are all active advocates for the issue in the broader community. Part of this advocacy is to respond to requests for trainings at additional sites nationwide to promote a community-based response to the issue.
- C** Networking has primarily involved participation in various fora and the utilization of funds from other sources to produce and promote more patient and clinician resource materials. Presenting either the project or training at a variety of national conferences has also been an active part of the project.
- C** Sustainability has been a focal point for the project and has been targeted through two endeavors. An Ad Hoc Committee on Violence Against Women was formed to write and advocate for the publication of a Position Statement and Clinical Guidelines from ACNM on the issue. Additionally, along with the Project Director, the Committee is spearheading the inclusion of domestic abuse as part of the core competencies in midwifery curriculum. The Position Statement and Clinical Guidelines were published in October 1995 and espouse "zero tolerance" and universal screening. This established screening as a standard of care for nurse-midwives. The core competencies are currently under review and the amended materials have been presented. If accepted, all future midwifery students will learn assessment and intervention of domestic abuse as a standard of care. Finally, the project supports site visits to schools and clinical sites as they integrate this material into their practices and is establishing an ACNM office as a resource for information.

Education programs were asked to submit their pertinent curriculum materials before the project began. They will be assessed at 12, 30, and 36 months post-TOT for changes in the curriculum. All participants of any of the trainings complete an on-site pre-test. Post-tests will be mailed at 6 and 12 months post-training. Forty-six of the fifty midwifery programs in the United States attended one of the TOTs. This represents a total of about 900 students impacted in the first year post-TOT. The Regional Workshops and additional presentations were attended by approximately 325 persons. Midwife clinicians see approximately 310 women per month; the impact thus far exceeds 750,000 women.

### ***Family Violence Prevention Fund (FUND)***

**Contact:** Ms. Esta Soler, Executive Director

Family Violence Prevention Fund

383 Rhode Island Street, Suite 304

San Francisco, CA 94103-5133

Telephone: 415-252-8900

Facsimile: 415-252-8991

Health Resource Center on Domestic Violence Toll-Free Number: 1-888-RX-ABUSE

**Program Type:** Policy development and reform, domestic violence education and prevention

**Target Population:** The general public through national public education and prevention campaigns, as well as the justice, health, and child welfare systems, and policy makers. Special projects with Hispanic and Filipino immigrant battered women.

**Setting:** Hospitals and clinics, courts, and the workplace nationwide.

**Program Description:** Established in 1980, the Family Violence Prevention Fund (FUND) is a national nonprofit organization focusing on domestic violence education, prevention, and policy reform. Funding sources include Federal and State grants, funds from private foundations and corporations, and fundraising activities. Throughout its history, FUND has developed pioneering prevention strategies in the justice, public education, and health fields. FUND publications and model programs have been distributed to and replicated in every state and several foreign countries. The FUND's divisions address different aspects of family and domestic violence:

- C Health Resource Center on Domestic Violence: FUND functions as the national clearinghouse for domestic violence as a health issue, distributing information to researchers, health care and domestic violence professionals, and others. It develops policy papers, resource materials, and training programs on domestic violence for a variety of health settings, including emergency, primary care, and obstetrics/gynecology. FUND has also developed a model emergency department program and resource manual for physicians, nurses and social workers.
- C Children's Program: FUND developed a national curriculum on domestic violence for family preservation practitioners designed to teach skills in identifying and intervening

- effectively with victims, abusers, and children. FUND conducted a national training-of-trainers program to develop multi-disciplinary training teams to provide education on family violence to family preservation practitioners. Soon to be published is a similar curriculum for child protective services workers. FUND is also developing a comprehensive plan for the first collaborative community-based program that focuses on prevention of child abuse and partner abuse within the same context. In the child custody arena, FUND has authored a curriculum entitled *Domestic Violence: Resolving Custody and Visitation Disputes*.
- C National Workplace Resource Center on Domestic Violence: assists businesses and labor organizations address the human resource policy, workplace safety and security, legal concerns, and other issues that affect employees, managers, and business owners dealing with domestic violence.
- C Battered Immigrant and Refugee Women’s Rights Project: a community-based domestic violence prevention education project with components for Hispanic and Filipino battered women to expand their access to legal assistance and culturally appropriate services.
- C Public Education: FUND launched in 1994 the first national public education campaign designed to promote prevention and promotion entitled, *There’s No Excuse for Domestic Violence*. The campaign includes television, radio, and print PSAs, community organizing, etc.
- C Judicial Education Project: works to improve courts’ handling of cases involving domestic violence. FUND has crafted two sets of national training curricula—one for judges presiding in the criminal courts and one for judges hearing civil court cases—and is developing complementary interactive software for each. Another program being developed is to educate judges on how domestic violence affects children.
- C Public Policy: focuses on highlighting the public health dimensions of domestic violence and the need for concerted prevention and education efforts. FUND worked closely with policy makers to establish a national violence against women prevention program under the auspices of the Centers for Disease Control and Prevention.
- C San Francisco Family Violence Project: provides specialized services and training on domestic violence to law enforcement professionals, judges, health care professionals, and other service providers.

***Massachusetts Older Women and Domestic Violence Prevention Project***

**Contact:** Diana Laskin Siegal, Acting Director, Elder Care  
 Massachusetts Older Women and Domestic Violence Prevention Project

Department of Public Health  
250 Washington Street, 4th Floor  
Boston, MA 02108  
Telephone: 617-624-5407  
Facsimile: 617-624-5075

**Program Type:** Professional education and training, policy development and reform, training of peer leaders, public education and awareness building, coordination among several agencies working in areas connected with older women and domestic violence.

**Target Population:** Service providers, older women and older battered women statewide, with an emphasis on cultural diversity and outreach to minority populations, including African American, Hispanic, and Asian American populations.

**Setting:** Massachusetts.

**Program Description:** The Massachusetts Older Women and Domestic Violence Prevention Project, started in 1994, is one of five organizations funded by the U.S. Administration on Aging. The project uses collaborative relationships to provide cross training for service providers, conduct a media campaign, conduct a peer outreach worker component, build a very diverse advisory board, and educate the general public and especially older women. Specifically, this project:

- C established ongoing relationships among four co-sponsors—the Massachusetts Department of Public Health, Massachusetts Executive Office of Elder Affairs, the Massachusetts Association of Older Americans, and the Massachusetts Health Research Institute—and three partners—the Massachusetts Coalition of Battered Women’s Services, the Massachusetts Coalition of Rape Crisis Services, and the Network for Battered Lesbians and Bisexual Women;
- C developed training curricula and held professional training programs at five regional training sites which covered almost the entire state, targeting service providers from networks such as Elder Services, Protective Services, Battered Woman’s Services, Rape Crisis Centers, Home Care Cooperations, community health centers, guardianship agencies, hospitals, police, and legal services;
- C included substantial emphasis on cultural diversity in staffing the project administration, recruitment of peer leaders, outreach to minority older women, and in creation of an Advisory Board;
- C conducted peer leader training programs, with emphasis on outreach to minority populations, including African American, Hispanic, and Asian American populations;
- C developed and updated a resource manual describing state service providers and other resources;

- C worked with batterer intervention programs to promote intervention and services for older men;
- C worked with the only existing support group for older women to extend services to more older battered women;
- C developed brochures and posters, conducted public awareness raising activities, and presented at numerous workshops;
- C provided technical assistance to physicians and nurse training programs of the Massachusetts Medical Society and SANE nurse education program;
- C included the Older Women and Domestic Violence Prevention Project as a module in the Harvard Upper New England Geriatric Education program;
- C developed and will develop articles for publication in national health and gerontological journals; and
- C disseminated and will disseminate project materials to State Units on Aging, state health departments and state domestic violence coalitions, the public, and professionals.

***WomanKind: Support Systems for Battered Women***

**Contact:** Ms. Susan M. Hadley, M.P.H.

Founder and Director

WomanKind: Support Systems for Battered Women

Fairview Health System

6401 France Avenue South

Minneapolis, MN 55435

Telephone: 612-924-5775 / Facsimile: 612-924-5012

**Program Type:** Advocacy/Case Management Services, Education/Consultation for Health Professionals.

**Target Population:** Victims of domestic abuse entering the health care system through urban and suburban hospitals. African American, Native American, Asian American, and Hispanic women generally utilize the urban hospital location.

**Setting:** One urban and two suburban Minneapolis hospitals and 50 affiliated clinics.

**Program Description:** The first program of its kind in the United States, WomanKind was founded in 1986 to better identify and treat abused women who come into the health care system through two suburban hospitals. In 1994, services were expanded to the urban hospital. WomanKind's goal is to integrate the issue of domestic abuse into the total health care of each patient, resulting in overall system change whereby routine assessment and identification, combined

with early intervention, may result in prevention of more serious injuries and symptoms to women and their families.

Nearly 100 clients are referred each month to WomanKind from inpatient and outpatient sources, as well as the surrounding community. WomanKind provides a connection between the victim in the health care setting and available community resources. It offers a safe, supportive, nonjudgmental environment, 24 hours-a-day, seven days-a-week, in which women can receive support, sort options, set priorities, and make decisions. Advocacy services provided to abused women include:

- C crisis intervention;
- C evaluation of domestic abuse issues;
- C development of a protection plan/action plan;
- C setting of short- and long-term goals;
- C support, education, and ongoing assistance; and
- C community referrals.

WomanKind staff and volunteer advocates are available to assist women during and after their emergency department visit or hospital stay. The services are also available for referrals from affiliate clinics, as well as community residents. A weekly support group, held in a confidential location, is available for women who are or have been in an abusive relationship. There is no charge for WomanKind services.

WomanKind also provides education to and consultation with hospital staff and other health professionals to assist them to more readily identify and treat abused women. Educated professionals often intervene at a point where abuse can be identified, and support and information about available community resources can be given.

The WomanKind program has been selected by the Centers for Disease Control and Prevention to participate in a two-year evaluation project on health system intervention for victims of domestic abuse and violence. The evaluations will assess the services provided by WomanKind staff in the areas of case management/advocacy services, professional training and education, and communication and networking with community service agencies.

WomanKind is nationally recognized and has been profiled in publications of the *Journal of the American Medical Association*, *The Journal of Emergency Nursing*, *Hospitals*, *Minnesota Medicine*, *Medical Economics*, *Emergency Medicine News*, and *Women's Health Issues*. It has been featured on health care reports of the *NBC TODAY Show*, *Lifetime's Physician's Journal Update*, and on *Today's Breakthroughs*, *Tomorrow's Cures*.

***B. Keynote Address Presented to the National Invitational Meeting  
on Prevention of Family and Intimate Partner Violence***

***Improving the Response to Family and Intimate Partner Violence,  
presented by Vincent J. Fontana, M.D., FAAP\* on September 15, 1996***

This afternoon I would like to share some thoughts with you in your roles as participants in HRSA's goals in studying the ways and means of preventing and breaking the cycle of family and intimate partner violence. We all have in our work with children and families learned a great deal over the years in talking with parents, children, professionals, community leaders, as well as politicians. So, I thought it worthwhile to share some of the more timely lessons I have learned over the last three decades.

Violence is a public health problem that is sweeping American society and is claiming young victims and adults at record rates. The most alarming trend in this country is the extent to which our children are killing other children. According to the National Center for Health Statistics, there are on average 65 homicides in the United States every day and 450 victims, of all ages, every week. These figures translate into 2,000 homicides a month and an estimated 24,500 Americans murdered each year. Child maltreatment kills as many as 4,000 children each year, and in New York City an average of 2 children each week die as a result of abuse and neglect. An estimated 3 to 4 million American women are the victims of domestic violence annually—"estimated" because many cases go unreported. Domestic violence in America claims the lives of more than 10 women every single day. Nowhere are the effects of this human violence so starkly revealed as in our hospital emergency rooms. We see the battered bodies of children, broken bones, gunshot wounds, wife beatings, incest, rape, and elderly abuse. The problem is enormous, and it is having tremendous impact on our health, child welfare, educational, and penal systems. The psychological impact on children and adults who are abused or neglected is enormous. Abused children as well as those who witness parental violence are more likely to use physical violence against others when they are older.

Family violence is inextricably linked with unbearable stress, with impossible living conditions, with material or spiritual poverty, with distorted values, with disrespect for human life, and with drug addiction, alcoholism, assaults, murders, and the other ills in the midst of which we live. It is a symptom of not just family trouble, but neighborhood and community trouble as well.

If we are to save ourselves and achieve any amount of success with the devastating problem of family and intimate partner violence that confronts our society, we must go to the root causes of violence. As with any disease, the most effective way to combat family violence is to treat the cause. I believe that the breakdown of the nuclear family and the decomposition of our communities

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\*Medical Director, Pediatrician-in-Chief, The New York Foundling Hospital, Author of  
"SOMEWHERE A CHILD IS CRYING" and "SAVE THE FAMILY, SAVE THE CHILD."

contributes very dramatically to the violence in our country. Violence and hatred begin in the home. We must restore a sense of family, a renewal of what parenting is all about. Let us begin by training parents, particularly those at risk of abusing their children. We must empower parents as primary models for their children by improving their parenting skills and cognitive knowledge. And equally important, teach them how to handle the pressures of being a parent. We must teach our young children the values that work and make a civilized society possible.

Teachers have a responsibility to teach common civility, respect, and self-respect. Respect for the rights of others. Respect for human life and the quality of life. Train youth in conflict resolution, mentor young people with special adults who can provide a positive, caring influence and a standard of human conduct. Counsel the young victims of violence so that they do not become the future perpetrators of violence. Limit the access of youth to alcohol, drugs, and firearms.

There is no question that far reaching social and economic changes in our nation must take place if we are to fundamentally alter the lives of our young people and families and thereby prevent the violence in our communities. We also have to reckon with the social environment of our times, namely, our violent drug-infested streets, the violence in our schools, and the glorification of sex and violence in entertainment, media, and publications.

To reduce the heavy toll of substance abuse on family violence, care providers must take a family-centered approach to treatment. Children's services must be a part of the parent's rehabilitation program. It is pointless to treat users of alcohol and drugs and ignore what might be happening to their children. We must establish support services for parents under stress, such as child care, respite care, crisis nurseries, shelters, parent help-lines, and a community network of self-help groups. Let it not be thought that funding a chain of such programs will take away from the war against poverty or the war against drugs, or the war against crime. We may never know in what heart of darkness lies the deep-down seed that grows into family and intimate partner violence, but we do know that poverty and crime and the drug epidemic feed into societal violence, and violence feeds into them.

To address the problem of child and spousal abuse in clinical practice, there must be wider use of domestic violence protocols in adult and pediatric medical care. The engagement of preventive interventions should include both children and their mothers. The overlap between the victimization of children and their mothers suggests a need for a redefinition of both problems, focusing on violence in the family. We need to be aware that the child within a violent family unit is never an innocent bystander, oblivious to the violence. The child is always involved emotionally and is at high risk for becoming physically or sexually abused. Children are never safe from domestic violence. There is a need for stronger linkages to be established between schools, law enforcement, drug rehab programs, shelters for battered women, child protective service workers, and child care agencies. Last but not least, there must be clearly defined laws for the protection of children and victims of domestic violence.

A multidisciplinary approach is critical when addressing the issue of family and intimate partner violence. It is impossible to approach a multidisciplinary problem with a single discipline service unit. We must develop a multidisciplinary human service unit which can cut across many of the traditions and unworkable rules and regulations that are built into most human service delivery units. Turf barriers are still a problem and an impediment to future progress. We must develop strong successful linkages between community-based programs, city agencies, and the public sector. We must develop within the bureaucracy a multidisciplinary approach in dealing with the causes and effects of family violence if the best interests and safety of the community are to be achieved. There are basically four “first points of entry” to the system which responds to child abuse, spouse abuse, and elderly abuse, namely, medical, law enforcement, mental health, and child protective and victim services. Currently, cities and states have a complex array of programs and initiatives involving all these systems. Unfortunately, there is no mechanism or plan in place that provides and ensures a coordinated, cooperative effort to communicate in the intervention, prevention, and treatment of family violence. Such a plan would maximize and more effectively utilize the resources which are now available, and provide the opportunity for the exchange of ideas and information by professionals from the different disciplines. This type of interagency communication, cooperation, and coordination will ensure success in the achievement of our ultimate goal, namely the prevention of family and intimate partner violence.

The goals of preventive interventions include the reduction of the risk factors associated with violence, the improvement of outcomes of individuals or families exposed to such risk factors, and the provision of protective factors that could mitigate or buffer the individual from the effects of violence.

There are two things that can undercut and sometimes even totally sabotage our efforts in the development and implementation of programs aimed at the prevention of violence. One is the absence of national policy and leadership, and the other growing out of the former is the uncoordinated, fragmented, and oftentimes wasteful overlapping of systems which are meant to deliver medical and social services to families at risk. Developing a research agenda for the epidemiology of family violence will give us much needed information on causes and consequences of violence which will help achieve our prevention goals. We need to gain a better, overall, system-wide understanding of family and intimate partner violence, including more accurate documentation of fatalities and incidents. More research is needed to determine effective ways to prevent violence and violent behavior through the implementation and evaluation of violence prevention programs. I would expect the President of the United States to provide leadership by committing major resources to research and to the development of model programs that demonstrate ways to prevent violence in different kinds of communities. Governmental leadership is needed to foster the integration of research from related fields that offer significant insights into the causes, consequences, and prevention of societal violence. The multi-nature of family and intimate partner violence requires developing specialized inter-disciplinary expertise and opportunities for collaborative research studies.

Early intervention is the top priority for every program and policy addressing family violence. There are ways to effect early intervention that can strengthen the family and prevent violence at the same time. We have the know how, and we have the technology for instant communication to effect a nationwide plan of action. We have all the resources necessary for the development of comprehensive, coordinated, community-wide, family-centered prevention programs. We know what works. Prenatal and postnatal care, education for parenting, preschool programs, crisis nurseries, homemaker services, self-help services, home visits, lay therapists, day care, and a shopping list of other successful preventive programs have all proved themselves. I would like to see a program in which a complete package of essential human support services are pulled together at the neighborhood level, with all previously separated programs linked together in one Family Center. However, there are obstacles that must be overcome. In addition to a lack of adequate funding, there is the complex array of services supported by many different funding streams and governed by a variety of eligibility requirements. If we are to be successful in making it easier for families to access critical services, we must make changes in our bureaucratic ways in order to maximize scarce resources and must do more to coordinate these services.

We must reach out to foundations, the business community, and national advocacy and professional organizations to help us achieve our goals and inform them of the benefits to the community at large. Let us persuade American philanthropists that there is no more important cause than the prevention of family and intimate partner violence. That no disease is more devastating to our national health, our environment, our work force, our children, and our battle against drugs and crime, than the pervasive disease of family violence. And, finally, there has been debate and question these past several months as to whether or not it takes a village to raise a child. Politics aside, my experience tells me that oftentimes it takes a village with its hospitals, schools, and child care centers to help a parent raise a child. It takes all of us. So let us build and support the villages that will help prevent violence within our families and in our society.

Can we stop child abuse, domestic violence, and elderly abuse? We can, if we have the courage to change the organization and bureaucracies we have been living with and make them work for the children and families who are being victimized by violence. America can no longer ignore the violence in our homes and communities. Working together we can make a difference, we can make it Un-American for any child or adult to be abused, exploited, or abandoned. It is the only way that will make it possible for us to break the cycle of violence breeding violence from generation to generation.

