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# Walden University

College of Health Sciences

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Julette Anderson

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2015

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Abstract

Effects of Education on Victims of Domestic Violence
by

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MSN/Ed, University of Phoenix, 2011

BSN, University of Phoenix, 2009

ADN, Kentucky State University, 1979

Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

March 2015

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Abstract

The purpose of this project was to improve support for victims of domestic violence. To that end, this project developed an evidence-based program to provide information about domestic violence including safe and confidential ways to seek assistance, rights as cohabiting intimate partners, and the resources available to community members. Several approaches were used to develop, validate, and plan for implementation and evaluation of this program, which was developed for 3 sites in Broward and Miami-Dade counties where the project is situated. The program logic model and the social ecological model, including the individual, relationship, community, and societal levels, were used to guide this project. In addition, scholarly works from 2000 to 2013 were selected from ProQuest, CINAHL, Ebscohost, Medline, and Ovid Nursing Journals to develop this program in collaboration with an interdisciplinary team of 7 community stakeholders including a physician, advanced practice nurse, law enforcement officer, pastor, and 3 recovery center directors with knowledge in these areas. Content validation involved incorporating feedback from the project team. The target population for the project includes women and men aged 18 or higher who have experienced domestic violence, homelessness, and drug addiction. Community operationalization of the initiative will be facilitated by implementation and evaluation plans developed as part of this project. The project includes community education that may help organize events and campaigns, increase domestic violence awareness among community members, and influence policy regarding issues pertaining to domestic violence.

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Dedication

In memory of my loving mother Mabel Louisa Linton. You were an inspiration to all. You are greatly missed and will forever be in my thoughts! You have always encouraged me to continue with my education. This is for you Mom!

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# Section 1: Overview of the Evidence-Based Project

## Introduction

The purpose of this study was to improve support for victims of domestic violence in Broward and Miami-Dade counties. An educational program was developed and implemented to help meet the educational needs of displaced victims of domestic violence. The target population was women and men between the ages of 18 and up with domestic violence issues, homelessness, and drug addiction.

The ultimate goal of the work of violence prevention is to stop violence before it begins. In order to prevent violence, it is important to implement programs and policies that can reduce risk factors and increase protective factors. Domestic abuse can take many forms and they are all about power and control. The Power and Control Wheel is based on the assumption that the purpose of the violence is to have power and control over a partner. The Power and Control Wheel describes the different tactics an abuser uses to maintain power and control over his/her partner. The Affordable Care Act created new federal guidelines, which include screening and assessment for domestic violence as a basic women's preventive health service (Futures without Violence, 2012). Violence against women is costly. Women of reproductive age are at greatest risk. Reproductive health issues including sexually transmitted disease (STD), human immunodeficiency virus (HIV) transmission, miscarriages, and risky sexual health behavior are linked to violence.

Domestic violence is also called intimate partner violence because it is often caused by a husband, ex-husband, boyfriend, or ex-boyfriend. While it is true that

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intimate partner assaults are also committed against men, women experience intimate partner violence at greater rates than men. An article by *Womenshealth.gov* (2011) explained how people of different races, education levels, and ages experience domestic violence. The article also pointed out that the number of women that are abused in the United States was more than five million. Domestic violence includes physical abuse, emotional abuse, and sexual abuse. Domestic violence is associated with untreated illness, chronic pelvic pain, sexually transmitted infections, and depression experienced during abusive relationship. Violence against women is common and has gynecological health effects; therefore, screening for domestic violence in health care settings, and providing health education materials to clients improved women's health outcomes. In addition to seeking assistance for medical problems, injuries, obstetrical or gynecologic problems, domestic violence victims also seek assistance for psychiatric symptoms.

Coker, Smith, Bethea, King, and McKeown (2000) noted that women who disclose physical violence are almost three times more likely to experience a sexually transmitted infection than women who do not disclose physical abuse. Hathaway et al. (2000) noted that 40% of pregnant women who were exposed to abuse, stated their pregnancy was unintended, as compared to 8% of non-abused women. Silverman, Decker, Reed, and Raj (2006) explained that 40% to 60% of women who were abused in the year prior to, and during a recent pregnancy were more likely than none abused women to report high-blood pressure, vaginal bleeding, severe nausea, kidney infections, or urinary tract infections during pregnancy. Additionally, 17% of children born to abused mothers are likely to be underweight and more than 30% more likely to require

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intensive care upon birth as compared to other children. The focus of this project was to develop an educational program for displaced victims of domestic violence. This program served as a useful educational tool for health care providers, who manage victims of domestic violence.

## Problem Statement

Interpersonal violence toward women is a major health problem across the world and a major health care issue in the United States with 5.3 million incidents of interpersonal violence reported each year in the United States among women 18 years of age or older (Centers for Disease Control, 2011a). Hodges and Videto (2011) noted that the serious nature of interpersonal violence is a valid reason for human service professionals to investigate, develop, and implement programs for victims of violence. A group of researchers at Johns Hopkins Bayview Medical Center conducted a study in 1997 and found a link between childhood abuse and adult health problems (Doctor's Guide, 1995). One of the findings listed was that, "the least healthy group was the respondents who said they were abused as both children and adults; 50% of women abused as children were also abused as adults" (Doctor's Guide, 1995, p.2). Assessment for past sexual trauma, as well as for more recent or ongoing trauma such as domestic violence, is crucial to identifying and treating the trauma (Holland, Finger, & Carter, 2000). The problem addressed in the proposed project is the current need for an evidence-based program for displaced victims of domestic violence.

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## Purpose Statement and Objectives

An educational program, Partnership Against Domestic Violence (PADV; 2013), improved safety at home. The goal of the project was to develop an educational program that reduce risk factors effectively, and increase protective factors for victims of domestic violence. The intent was to teach women and men with a history of violence how to increase safety of the home and reduce risk of future violence. This educational program would be taught at three different sites.

The first site is a structured, comprehensive residential substance abuse treatment program for women, pregnant women, and women with children up to age 5. This site has a capacity of 40 residents. This site was chosen because of the issues amongst women and children with domestic violence, psychiatric problems, and issues with births of substance exposed newborns.

The second site is a recovery center, which enhances the lives of women with children who have issues with domestic violence, and suffer from substance addiction. This five-acre campus includes 40 apartments and serves 60 families. A child care center and an administrative/treatment facility are located on this campus. The third site is an outreach center for women and children. This center provides services for 50 women, children, and families. Counseling offered to those desiring to help bring about positive change in their lives.

## Project Goals

Project goals were carried out through collaboration with an interdisciplinary team comprised of health care professionals, a representative from each of the sites, and

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members from the community who showed interest in the program. Team members guided the development, implementation, and evaluation of the program. A 2-day domestic and family violence educational program was developed, along with plans for implementation and evaluation of the program. The aim of this project was to reduce domestic and family violence in new and emerging communities. This was done by increasing the awareness, knowledge, and self-care agency of displaced victims of domestic violence.

The project goals included:

1. A program for implementation at three different sites, all in Broward and Miami-Dade County that would provide information about domestic violence, safe/confidential ways to seek assistance, rights as cohabiting intimate partners, and the resources available to them.
2. Validate the program using scholars with expertise in the areas.
3. Implement the program.
4. Evaluate the program.

These goals assisted in the prevention of domestic violence through community outreach and education.

## Significance/Relevance to Practice

Laurence and Spalter-Roth (1996) reported cost estimates of $5 billion to $10 billion the United States spent annually for issues related to domestic violence. In the United States alone, the health-related costs of rape, physical assault, stalking, and homicide committed by intimate partner exceed $5.8 billion each year. Direct medical

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and mental health care services from that amount consumed nearly $4.1 billion, with $1.8 billion for the indirect costs of lost productivity or wages (CDC, National Center for Injury Prevention and Control, 2006, as cited in Carretta, 2008).

Consumers and providers alike are demanding cost containment. For all women, the advent of health-care reform is a victory. As for domestic violence victims, it is a lifeline (Rosenthal, 2010). Critics of the health care law have argued that it will be too expensive. Others say that by treating domestic violence early and aggressively money can be saved (Rosenthal, 2010). Intimate-partner violence costs the United States billions of dollars each year in lost workdays and expenses related to mental-health and substance abuse treatment (Rosenthal, 2010). A major change in the health care law is that women's domestic-violence insurance claims cannot be denied as part of a pre-existing condition. Health insurance companies can no longer designate interpersonal and domestic violence as a pre-existing condition as they have done in the past.

In order to improve preventive medical care, the Health-Care Reform Act (2010) stated that insurance companies can no longer charge for many basic screenings, including domestic violence screening. Rosenthal (2010) noted that domestic violence victims will not face gender discrimination or lifetime caps on benefits. Victims of domestic violence will not face the struggle of paying too much for health care while trying to rebuild their lives after suffering domestic violence. Now, victims of domestic violence need not be worried about access to health-care.

Funding from the government is approved and established to support the Violence Against Women Act (VAWA), legislation at the federal level, passed in 1994 and

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renewed every 5 years. Programs for reducing domestic violence are funded by VAWA (Foster, 2010). The Office on Violence against Women (OVW) (Foster, 2010) awarded more than $3 billion in grants to organizations to reduce domestic violence, dating violence, sexual violence, and stalking. Services to victims were strengthened by these grants and offenders held accountable (Foster, 2010). In Fiscal Year 2009, grants totaling more than $613 million were awarded by the OVW (Foster, 2010).

Radford and Gill (2006 as cited in Foster, 2010) looked at how cost and performance measures related to the impact of government policies on domestic violence in the United Kingdom focused on items that were easily measured. These items included the number of arrests for domestic violence and the number of domestic violence claims reported to police. West Virginia (WV) crime report statistics showed that the focus in the United States may be similarly skewed. The number of domestic violence incident investigations conducted by the WV police department increased over 1,000% from 1981 to 2005; also arrests increased nearly 3,000% (Foster, 2010).

Domestic violence has many other negative consequences for its victims. Physical health outcomes included injury (e.g., laceration, fractures, and internal organs injury), unwanted pregnancy, gynecological problems, and sexually-transmitted infections including HIV/AIDS. Other physical health outcomes included miscarriage, chronic pelvic pain, headaches, permanent disabilities, asthma, irritable bowel syndrome, and self-injurious behaviors, such as smoking and unprotected sexual activity (Carretta, 2008).

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Leserman (n.d.) explained how researchers looked at a large study of several primary care practices and compared women with childhood (no adulthood) sexual abuse ($n$ = 204) to those without abuse ($n$ = 1257) on many health status measures. The result showed that adult women who have experienced childhood sexual abuse were more likely to report abdominal pain (46% versus 28%), diarrhea (36% versus 24%), constipation (39% versus 27%), and pelvic pain (24% versus 11%) as compared to women without an abuse history.

## Evidence-Based Significance of the Project

Domestic violence has severe emotional and physical implications for women. Emotional health consequences of abuse include depression and post traumatic stress disorder, both of which fundamentally affect the quality of a woman's daily life and can require long-term counseling and group therapy to overcome. Women who experience abuse exhibit higher rates of substance abuse, suicide attempts, visits to the emergency department, and physical symptoms including poor appetite, bruising, vaginal discharge, abdominal and pelvic pain, diarrhea, breast pain, headaches, chest pain, dyspnea, and insomnia (Violence Against Women: Effects On Reproductive Health, 2002). Consequently, knowledge of domestic violence is important for clinicians.

Towsend (2012) looked at sociocultural theories as they related to societal influences. Towsend noted that although social scientists agreed that some biological and psychological aspects are influential, they concluded that aggressive behavior is primarily a product of one's cultural and social structure. Societal influences, as noted by Tardiff (2003), may contribute to violence when individuals realize their needs and desires are

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not being met relative to other people. As a result, with the limited access through legitimate channels, poor and oppressed people are more likely to resort to delinquent behaviors in an effort to obtain desired ends. This lack of opportunity and subsequent delinquency may somewhat contribute to a subculture of violence within a society.

The National Center for Health Statistics (2009) reported that with regard to ethnicity, statistics showed that White Americans were at the highest risk for suicide, followed by Native Americans, African Americans, Hispanic Americans, and Asian Americans. Anderson and Aviles (2006) cited Lee et al. (2002) African-American women and Hispanic women experience greater mental health consequences when they are victims of domestic violence. These women will be dealing with the stigma associated with domestic violence, and race, and the negative effects they have on the availability of and access to culturally-sensitive services (Lee et al. 2002).

According to Social Issue Report (2011), the Department of Justice most recent survey is listed that 1.9 million women are assaulted annually. The report listed 68% of women are abused by an intimate partner. Specifically, women of low socioeconomic status tended to experience domestic violence more frequently and more severely, while also having fewer resources and lacking access to services to protect themselves. Structural barriers such as poverty, low educational attainment, and lack of access to information make escaping violence more difficult as these barriers limit women's knowledge of available resources and their abilities to be financially independent. Anderson and Aviles (2006) reported that domestic violence is portrayed and perceived as a minority issue. Anderson and Viles (2006) cited Martinson (2001), Weiss (2001),

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and Bograd (1999) domestic violence victims are routinely portrayed as poor women of color.

Anderson and Aviles (2006) cited Sullivan and Rumptz (1994) African American women were more likely to be living below the poverty level, to be the sole providers of their families, to have more children living with them, and to be less likely to have access to a car. On the other hand, Anderson and Aviles (2006) cited Menjivar and Salcido (2002) Hispanic women experience language barriers, isolation, lack of access to minimum wage jobs, and uncertain legal statuses.

Health care service providers perceive immigrant women as accepting of domestic violence because they believe that these immigrant women brought this belief and culture of acceptance with them. These women are more likely to lack a social network, making it easier for the abuser to isolate and control them. African American women do fear of being ostracized within their community for reporting abuse. Anderson and Aviles (2006) cited Martinson (2001) African American women may be viewed as contributing to the racial stereotypes and criminalization of the African American male.

Empowerment is the most effective approach to provide necessary services to victims (Social Issue Report, 2011). Empowerment theory underpins services provided by many clinics, shelters, and nonprofit organizations. With this approach, it is believed that victims of domestic violence should have access to information, education, and other necessary social and economic support to make informed decisions that best reflect their interests and needs. The empowerment approach uses knowledge dissemination, training, and counseling to create a set of services that victims control, such as post-victimization

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assistance and risk minimization (Social Issue Report, 2011). An educational program is needed in the community to empower displaced victims of domestic violence.

The CDC conducts research on violence, its causes, and effective prevention strategies. There are personal, peer, family, and social factors that may increase or reduce the chances that a person will become a victim or perpetrator of violence (CDC, 2011a).

## Implications for Social Change in Practice

Successful change requires going below the waterline, and because structure influences behavior, the only way to truly change behavior within the system is to identify, target, and change the underlying structures (Kelly, 2011). The problem must be thoroughly studied and analyzed. One should develop a clear understanding of the type, size, and scope of the problem. Problem analysis should focus on understanding the problem, not on generating the solutions (Ketter, Moroney, & Martin, 2008). There are several ways in which my educational program made a difference on society.

Battered and displaced women and children were empowered by federal legislation such as the Violence Against Women Act. The program alert and educate the public on how to recognize domestic violence and what to do about it; on teen dating violence; on the impact of family violence on children; and on domestic violence against the disabled and the elderly and other marginalized populations (Womenshealth.gov. 2011). The program promotes partnerships with corporations and foundations to design and fund more innovative programs to eliminate domestic violence and to foster development of safe alternatives within local communities (Partnerships Against Domestic Violence, 2013). Victims of domestic violence are aware of the national

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Directory of Domestic Violence Programs through Partnerships Against Domestic Violence (Partnerships Against Domestic Violence, 2013). This directory provides up-to-date information about domestic violence programs throughout the country (Partnerships Against Domestic Violence, 2013). Advocates and others in the domestic violence field have knowledge on how to start, maintain, and structure financial education programs within their own communities to provide battered and displaced victims of domestic violence with better financial information to help them remain free from their abuser.

Participants of an educational program for displaced victims of domestic violence and their families were provided with information about domestic violence, safe/confidential ways to seek assistance, rights as co-habiting intimate partners, and the resources available to them. A variety of services, not limited to crisis intervention, such as assistance in securing medical treatment for injuries, and information on legal rights were provided (Partnerships Against Domestic Violence, 2013). Support groups were conducted and referrals made to other partnering agencies (Partnerships Against Domestic Violence, 2013). Domestic violence prevention was promoted through community outreach and education. Educational classes were conducted on the prevention of domestic violence and on skills necessary to enhance relationships (Partnerships Against Domestic Violence, 2013). According to Shepard (2008), mobilizing communities to prevent domestic violence involves engaging communities in supporting, and implementing prevention strategies that target change in individuals, as well as in the community and society.

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Strategies include educating the community, building support among key stakeholders for prevention efforts, developing programs that strengthen social networks, organizing community groups to challenge social norms that contribute to the use of violence, and advocating for community accountability. Community mobilizing strategies hold the potential for transforming those social norms and structures that are the root cause of domestic violence (Shepard, 2008). Many victims of domestic violence would not disclose the abuse unless they are directly asked or screened for domestic violence by the physician. It is imperative that health care providers directly inquire about possible domestic violence so victims receive proper treatment for injuries or illnesses and are offered further assistance for addressing the abuse.

## Definitions of Terms

*Affordable Care Act*: A federal statute signed into law in March 2010 as a part of the healthcare reform agenda of the US President Obama's administration. Signed under the title of the Patient Protection and Affordable Care Act, the law included multiple provisions that would take effect over a matter of year, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions (Whitehouse.gov, 2013).

*Delta*: The Domestic Violence Prevention Enhancement and Leadership through Alliances program seeks to reduce the incidence (i.e., number of new cases} of intimate partner violence (IPV) in funded communities. The program addresses the entire

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continuum of IPV from episodic violence to battering through a variety of activities (CDC, 2013).

*Interpersonal Violence*: Violence between individuals and is subdivided into *family and intimate partner violence* and *community violence.* The former category includes child maltreatment, intimate partner violence, and elder abuse, while the latter is broken down into acquaintance and stranger violence and includes youth violence; assault by strangers; violence related to property crimes; and violence in workplaces and other institutions (World Health Organization [WHO], 2013).

*IPV*: Intimate Partner Violence describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy (CDC, 2013).

*MAPP*: Mobilizing for Action through Planning and Partnership is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helped communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems (National Association of County & City Health Officials (NACCHO), 2013).

*NISVS*: National Intimate Partner and Sexual Violence Survey is a summary report presents data on the national prevalence of intimate partner violence (IPV), sexual violence (SV), and stalking among women and men in the United States (CDC, 2013).

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*VAWA*: Violence Against Women Act of 1994 is a United States federal law. The Act provides $1.6 billion toward investigation and prosecution of violent crimes against women, imposes automatic and mandatory restitution on those convicted, and allows civil redress in cases prosecutors chose to leave un-prosecuted. The Act also establishes the Office on Violence Against Women within the Department of Justice. Its coverage extends to male victims of domestic violence, dating violence, sexual assault, and stalking (Violence Against Women Act of [1994], 1997).

*Displaced Victims of Domestic Violence*: Victims of domestic abuse have unmet needs for both short and long-term housing. Shelters provide immediate safety to battered/displaced women and their children and help them gain control over their lives. The provision of safe emergency shelter is a necessary first step in meeting the needs of women fleeing domestic violence (National Coalition for the Homeless, 2007).

## Assumptions, Delimitations, and Limitations

An assumption is that communities can develop more effective responses to violence if they have a common understanding of the causes of domestic violence. This common understanding helps victims avoid conflicting responses that could undermine efforts to protect them and hold batterers accountable (Minnesota Advocates For Human Rights, 2003). Another assumption is that by increasing knowledge about dealing with domestic violence, women with a history of domestic violence will use that knowledge to promote their own safety and health.

One limitation of this project is that it is often difficult to gather and collect all the data that are identified as being needed for evaluation of such a program. Decisions about

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what data are essential and what data collection strategies are appropriate and available to the particular evaluation will be made. A four-level social-ecological model (SEM) will be used to understand better and prevent violence. Limitation of biological and personal history factors such as age, education, income, substance abuse, or history of abuse, increase the likelihood of becoming a victim or perpetrator of violence. Close relationships that may increase the risk of experiencing violence as a victim or perpetrator is a limitation. A person's closest social circle-peers, partners, and family members-influences their behavior and contributes to their range of experience. While evaluation planning is a part of this project, actual evaluation will be undertaken at a later date.

## Summary

Empowering displaced victims of domestic violence to know where and how to seek help for themselves and their families is desperately needed. The problem addressed in the project was the current need for an evidence-based educational program for displaced victims of domestic violence. The selected population was provided with an ongoing educational program for 3 months. This educational program effectively reduced risk factors and increase protective factors for displaced victims of domestic violence. Women and girls were empowered on services provided by many clinics, shelters, and nonprofit organizations. Displaced victims of domestic violence had access to information, education, and other necessary social and economic support to make informed decisions that best reflect their interests and needs. Following, is a review of scholarly evidence in section two from specific, and general literature, conceptual

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models, and theoretical framework pertinent to the project. Literature specific to the project includes a description of the Violence Against Women Act (VAWA).

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## Section 2: Review of Scholarly Evidence

### Introduction

Domestic violence affects a significant proportion of the United States population either as direct victims or as witnesses of abuse directed toward spouses or intimate partners, children, and elders. The American Association of Colleges of Nursing (AACN, 2006) recognized domestic violence as a special form of violence with high incidence and prevalence requiring health care interventions. Nurses frequently cared for victims of domestic violence. As members of the largest group of health care providers, nurses should be aware of assessment methods and nursing interventions that would interrupt and prevent the cycle of domestic violence.

### Literature Search Strategy

Several nursing and health databases were used in order to find scholarly and evidence-based literature relevant to the project. These included ProQuest database, CINAHL, Ebscohost, Medline, and Ovid Nursing Journals. Key search terms and combinations of search term used were: *domestic violence, victims of domestic violence, cycle of domestic violence, impact of family violence on children, domestic violence against the disabled, elderly, and other marginalized populations, evidence- based practice in domestic violence education, health disparities in the United States, culture* and *education*. The scope of the literature that was researched included scholarly works from 2000 to 2013. Current journals and websites of CDC, WHO, Library of Congress, and peer-reviewed literature were used.

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## Specific Literature for the Project

Literature specific to the project included a description of the VAWA. The program alert and educate the public on how to recognize domestic violence and what to do about it; on teen dating violence; on the impact of family violence on children; and on domestic violence against the disabled, the elderly, and other marginalize populations (Womenshealth.gov. 2011). The program promoted partnerships with corporations and foundations to design and fund more innovative programs to eliminate domestic violence and to foster development of safe alternatives within local communities.

Campbell et al. (2002) noted that a case-control study of enrollees in a multisite metropolitan health maintenance organization sampled 2,535 women enrollees aged 21 to 55 years. Campbell et al. revealed that abused women have a 50% to 70% increase in gynecological, central nervous system, and stress-related problems. Routine universal screening and sensitive in depth assessment of women presenting with frequent gynecological, chronic stress- related, or central nervous system complaints are needed to support disclosure of domestic violence.

Zenilman and Shahmanesh (2012) cited Yudin and Wiesenfeld (2012, Chp. 16, p. 152.) approximately 44% of all women have been the victims of an actual attempted assault at some time in their lives. Women who have suffered abuse may account for 22% to 35% of women seeking care for any reason in an emergency department. An estimate of 2 million cases of domestic violence occur each year in the United States, and a previous study using population-based national samples, estimated that 60% of women have experienced at least one form of violence in their adult life.

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Montero et al. (2011) noted the effect of different forms of interpersonal violence on women's health. A total of 10,815 adult women randomly sampled from primary health care services around Spain were included. There were four different categories. Thirty-seven percent of the women experienced lifetime violence. They concluded that the high prevalence of violence and its consistent association with a wide range of women's health problems suggested that violence seriously compromises women's health.

Ellsberg (2006) reported the results of the WHO study released in 2005. The results from the WHO revealed that intimate partner violence (IPV) is common throughout all the sites studied, although considerable variation was found within and between countries. Between 15% and 71% of ever-partnered women had been physically or sexually assaulted by an intimate partner. Peterman, Palermo, and Bredenkamp (2011) reported for the Democratic Republic of Congo (DRC) Minister for Gender, Family, and Children who stated that more than one million of the country's women and girls are victims of sexual violence.

The United Nations Population Fund [UNPF] (2011) revealed that 15,996 new cases of sexual violence were reported in the DRC in 2008. Sixty-five percent of the victims were children and adolescents younger than 18 years, with 10% of all victims younger than 10 years. Despite the alleged severity of violence against women in the DRC, and the attention it has received in popular press, little research provides data-based estimates of the magnitude or nature of the problem. Reliable, nationally

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representative estimates of rape and sexual violence in the DRC do not exist (Peterman, Palermo, & Bredenkamp, 2011).

Campbell, Lichty, Sturza, and Raja (2006) examined the relationship between sexual assault and gynecological health symptoms such as pelvic pain and painful intercourse in a sample of predominantly African American female veterans. Campbell et al. concluded from their study that African American female veterans who have been sexually victimized, experience more frequent gynecological health symptoms than those who had not been assaulted. The recommendation was that women be screened in health care facilities for a history of violence; that way, they would be able to refer victims to resources and treatment for assault-related health symptoms.

Carretta (2008) noted that according to researchers, domestic violence had many other negative consequences for its victims. Physical health outcomes included (e.g. lacerations, fractures, and internal organs injury), unwanted pregnancy, gynecological problems, and sexually transmitted infections including HIV/AIDS. Other physical health outcomes included miscarriage, chronic pelvic pain, headaches, permanent disabilities, asthma, irritable bowel syndrome, and self-injurious behaviors, such as smoking and unprotected sexual activity.

Montero et al. (2011) noted that many researchers examined the health consequences of violence by an intimate partner, as it was the most prevalent type of violence against women on a worldwide scale. But despite the significance of violence against women as a public health problem, few studies examined the health impact of violence perpetrated by persons other than intimate partners.

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Lathe, Mignini, Gray, Hills, and Khan (2006) reported that several gynecological factors were strongly associated with chronic pelvic pain. A comprehensive review evaluated over 60 risk factors in 122 studies and found strong and consistent association between chronic pelvic pain and presence of pelvic pathology, history of abuse, and coexistent psychological morbidity. These key gynecological and psychosocial factors provided potential targets for new therapeutic strategies for treating women with this disabling condition, for which current treatment options provide little relief.

Chronic pelvic pain is seldom caused by a single factor alone. Lathe et al. (2006) argued that abuse was strongly associated with depression in women so it was possible that women who were abused were depressed. As a result they complained of chronic pelvic pain more often. Additionally, the association between abuse, psychological morbidity and pathology, and chronic pelvic pain were sufficiently consistent and strong to suggest that they may well be casually related (Lathe et al. (2006).

**Other Evidence-Based Literature**

Other scholarly evidence that was used with the project includes the logic model which is a conceptual approach describing the activities of the project and the relationships among the activities, the theoretical foundation of the program, and the program's goal and objectives (Hodges & Devito, 2011). This model can be used in many ways once developed, including evaluation planning, program design, goal setting, communication with stakeholders, and program improvement (McKenna et al, 2008). A good program theory logically and reasonably links program activities to one or more outcomes for participants.

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Laurence and Spalter-Roth (1996) reported cost estimates of $5 billion to $10 billion in the US annually for issues related to domestic violence. In the US, the health-related costs of rape, physical assault, stalking, and homicide committed by intimate partners exceeded $5.8 billion each year. Direct medical and mental health care services from that amount consumed nearly $4.1 billion, with $1.8 billion for the indirect costs of lost productivity or wages (National Center for Injury Prevention and Control, 2006 cited in Carretta, 2008).

The CDC (2011a) conducted research on violence, its causes, and effective prevention strategies. Personal, peer, family, and social factors may increase or reduce the chances that a person will become a victim or perpetrator of violence. The CDC and its partners used this science-based information to help agencies and governments around the world develop programs to prevent violence-related injuries and deaths.

The DELTA program seeks to reduce the incidence of intimate partner violence (IPV) in funded communities. The program addressed the entire continuum of IPV from episodic violence to battering through a variety of activities. DELTA PREP (Preparing and Raising Expectations for Prevention), a 4 year project funded in 2007 to support an additional 19 state-level domestic violence coalitions, is a collaborative effort between CDC, the CDC Foundation, and the project's funder, the Robert Wood Johnson Foundation (CDC, 2011a).

Through participation in DELTA PREP, state domestic violence coalitions are better positioned to serve as catalysts for promotion and implementation of primary prevention programs, policies, and practices at the state and community levels (Centers

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for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, 2011a).

Shepard (2008) stressed mobilizing communities to prevent domestic violence, which involved engaging communities in supporting and implementing prevention strategies that target change in individuals, as well as in the community and society. Strategies included educating the community, building support among key stakeholders for prevention efforts, developing programs that strengthen social networks, organizing community groups to challenge social norms that contribute to the use of violence, and advocating for community accountability. Shepard noted, "Community mobilization strategies hold the potential for transforming those social norms and structures that are the root causes of domestic violence" (p. 1).

## Conceptual Models, Theoretical Frameworks

The model used to guide the project was the Social–Ecological Model which consisted of four-levels. The SEM helped to understand better, and prevent violence. The SEM is very useful in many ways. It allowed one to address factors that put people at risk for or protect them from experiencing or perpetrating violence (risk and protective factors), and the prevention strategies used at each level to address these factors. The first section, the Individual level, identifies biological and personal history factors that increased the likelihood of becoming a victim of domestic violence. The Individual level guides the project because it looked at factors such as age, education, income, substance use, or history of abuse. At this level, prevention strategies are design to promote attitudes, beliefs, and behaviors that actually prevent violence (CDC, 2009).

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The next level is Relationship, which examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. This level guides how data is collected from someone's closest social circle-peers, partners, and family members. Prevention strategies at this level include mentoring and peer programs design to reduce conflict, foster problem solving skills, and promote healthy relationships. Another level is Community, which guides the project by exploring the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur. The characteristics of these settings are looked at to see if there may be any association with becoming victims or perpetrators of violence (CDC, 2009).

The Societal level is the final section of the framework. This level looked at broad societal factors such as social and cultural norms to help create a climate in which violence is encouraged or inhibited. Societal factors on a larger scale include health, economic, educational and social policies helped to maintain economic or social inequalities between groups in society (CDC, 2009). Each level of the SEM is a level of influence and a key point for prevention interventions. It is important to implement programs and policies that reduce risk factors and increase model (CDC, 2009).

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## Summary and Conclusions

Domestic violence affects a significant proportion of the United States population either as direct victims or as witnesses of abuse. Literature specific to the project includes a description of the VAWA The program alert and educate the public on how to recognize domestic violence and what to do about it; on teen dating violence; on the impact of family violence on children; and on domestic violence against the disabled, the elder, and other marginalized population. The program promotes partnerships with corporations and foundations to design and fund more innovative programs to eliminate domestic violence and to foster development of safe alternatives within local communities. Routine universal screening and sensitive in-depth assessment of women presenting with frequent gynecological, chronic stress-related or central nervous system complaints are needed to support disclosure of domestic violence. The logic model is a conceptual approach and was used to describe the activities of the project and the relationships among the activities, the theoretical foundation of the program, and the program's goal and objectives. The Social-Ecological Model (SEM), which consists of four-levels, helps to understand better and prevent violence.

Following, is Section 3, which outlined the program's approach, including what communities needed to do, to prevent and aid victims of domestic violence. The involvement of many sectors working together at community, national and international levels is required.

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## Section 3: Approach

### Introduction

There is a growing awareness that communities themselves must take responsibility for preventing and aiding victims of domestic violence by establishing programs and services that meet the needs of their citizens. Domestic violence is a widespread social problem that is recognized by society as no longer a private matter (WHO, 2002). Although women can be violent in relationships with men and violence is also found in same-sex partnerships, the over-whelming health burden of partner violence is borne by women at the hands of men (WHO, 2002).

### Project Design/Methods

Given the stated problem addressed in the project, an educational program was developed for later implementation to help meet the educational needs of displaced victims of domestic violence. This educational program for these displaced victims was based on evidence from the literature. The long-term goal of the project was to develop a program that would reduce risk effectively and increase protection for victims of domestic violence. The target populations for this project were individuals with a history of being victims of domestic violence and who currently receive services from the three sites listed earlier in the study. Given the stated purpose of the project, the following steps were taken:

1. Obtain Institutional Review Board (IRB) approval
2. Assemble an interdisciplinary team

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3. Lead the project team in reviewing the evidence-based literature with the evidence-based team.
4. Develop an educational program delivery plan and program content.
5. Validate content/delivery of program
6. Develop an implementation plan and process
7. Develop a long-term evaluation plan for the educational program.

Each of these seven steps will be discussed below.

The final product associated with this project is an implementation-ready, validated educational program, including implementation and evaluation plans. Should the community decides to implement the program, they have a turn-key program customized to their community, constituencies, and population.

**IRB Approval**

Walden University provided IRB approval (approval # 02-26-14-0307637). Federal regulations require that research involving human subjects be subjected to an institutional review process. Institutional review board (IRB) is a committee that is responsible for ensuring that human rights and safety are protected and that research is carried out ethically and in compliance with federal guidelines (Burns & Grove, 2001 as cited by Zaccagnini & White, 2011). Project implementation began immediately after IRB approval.

## Assemble the Interdisciplinary Project Team

The first step in the project was IRB approval from Walden University. Next, was to assembly the interdisciplinary team to help situate the educational program in the

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context and the needs of the target population. Three community centers partnered in the development, implementation, and evaluation of the project. It is important to make clear each member's role which reduces the possibility of misunderstandings of each member's responsibilities to the team. One representative from each of these centers will be included in the interdisciplinary project team. In addition, one physician, one advanced practice nurse, and one administrative professional will be included on the team. Including some overlap in these roles, the final team will include three to five healthcare professionals or administrators in addition to the leader of the project.

The team will assist in the project development and implementation by collaborating during various stages of program planning and validation, and later in the implementation and evaluation phases of the project. It is necessary to involve an interdisciplinary team because members recognize and value dissimilar professional perspectives and overlapping roles. They share decision making roles in the community and at their individual institutions, and their leadership positions made them best suited to understand and meet the needs of the project participants. Collaboration with nursing professionals and professionals in the fields of domestic violence, law enforcement, and administration will be active throughout the project, especially during tool development and validation.

Having assembled this interdisciplinary team as the second step in the project, the team will be involve in decision-making for the entire project and will take ownership of the project following implementation. While I lead the team as a DNP student and project manager for the DNP project, upon graduation I will become a consultant and member of

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the team assisting the team to further revise, develop, evaluate and expand the educational program as needed.

## Project Team Literature Review

The literature review with the project team helps to identify needs related to the program. The review includes investigation of socioeconomic disadvantages associated with a range of psychological problems, such as lack of self-esteem or self-respect, powerlessness, frustration, and shame felt by displaced victims of domestic violence. Members from each discipline will examine the literature on domestic violence from their perspective and make contributions from their own experiences as project team members, and the results will be used to structure the project. Participants will also be able to verbalize and understand domestic violence, recognition of risk factors, identification of support systems and strategies to improve their health. Family members will be encouraged to become active participants for support and guidance throughout the program.

## Program Development

The interdisciplinary project team clarified the purpose and quantified realistic goals and objectives of the project with the development of appropriate goals, objectives, and outcomes for the project. This helped to increase the effectiveness of the planning, implementation, and evaluation process. The goals direct the overall intent and lead to the desired outcomes of the project. Outcomes, such as an increase in awareness and understanding of domestic violence, and how it affects people at home, and an increase in opportunities for participants to access resources and motivate participants to get involve

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and become part of the solution at work and in the community, was proposed as outcomes for the project.

The project team and the community centers they represent will aid in the development of the actual educational program. Strategies that will be used include educating the community, building support among key stakeholders for prevention efforts, developing programs that strengthen social networks, organizing community groups to challenge social norms that contribute to the use of violence, and advocating for community accountability. The physician and the APN will identify currents facts from evidence-based literature on domestic violence. The Officer from Law Enforcement will speak on how to keep communities safe. The minister from the local community church will speak to women and girls about domestic violence, how to prevent domestic violence within the family and how to keep the home safe. Community mobilizing strategies hold the potential for transforming those social norms and structures that are the root cause of domestic violence (Shepard, 2008).

**Validation of Content/Delivery of the Program**

Having a business budget in place enables an organization to plan ahead, prioritize allocations of funds, and gauge whether the financial predictions are being met. It also enables the organization to make educated decisions to enhance its business operations with added clarity and efficiency (Ketter, Moroney and Martin, 2008). When seeking funding, it is vital to document the need for the program and to have a detailed program plan and budget (Ketter et al, 2008). Violence costs the economy many billions of United States dollars each year in health care, legal costs, absenteeism from work, and

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lost productivity (Ketter et al, 2008). Evidence from around the world showed that victims of domestic violence and sexual violence had more health problems, higher health care costs and more frequent visits to the emergency departments throughout their lives than those without a history of abuse (Violence – A Global Public Health Problem, 2002).

Consumers and providers of health care services are demanding cost containment. For all women, the advent of health-care reform is a victory. As for domestic violence victims, it is a lifeline (Rosenthal, 2010). Critics of the health care law argued that it would be too expensive. Others say that by treating domestic violence early and aggressively could save money. Intimate-partner violence costs the United States billions of dollars each year in lost workdays and expenses related to mental health and substance abuse diagnosis and treatment. A major change in the health care law was that women's domestic-violence insurance claims cannot be denied as a pre-existing condition. Health insurance companies could no longer designate interpersonal and domestic violence as a pre-existing condition as they have done in the past.

In order to improve preventive medical care, the health-care reform stated that insurance companies could no longer charge for many basic screenings, including domestic violence screening. Rosenthal (2010) noted that domestic violence victims would not face gender discrimination or lifetime caps on benefits. They would not face the struggle of paying too much for health care while trying to rebuild their lives after suffering domestic violence. Now, victims of domestic violence need not be worried about access to health care.

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The cost of domestic violence can be classified as direct or indirect and encompass a myriad of issues. Line-item budgeting systems require the design of a standardized budget format that identifies all anticipated revenues and proposed expenses. The line-item budget chart will be used to implement the educational program for domestic violence.

Ketter et al. (2008) explained what program budgeting systems focus on: results, accomplishments, or impacts (outcomes). These outcomes are related to revenues (inputs). This type of budgeting systems is thought of as: "outcome budgeting" or "effectiveness budgeting" (Ketter et al., 2008). All categories created in this line-item budget will be sufficient to cover all major items of revenue and expense for this program. The miscellaneous category for both revenues and expenses ensured that the line-item budget format will accommodate all budget items.

Project partner institutions, member representatives included on project teams, and other team members will donate space in a church and a community center to accommodate participants. Items such as, administrative office, waiting room, classroom, private counseling rooms or cubicles, donated furniture, office equipment, and supplies will be from donations. A secure, password-protected system of recording, tracking, and maintaining sensitive files will be established. The physician and the APN will have the current facts from evidence-based literature on domestic violence. The minister from the local community church will speak to women and girls about domestic violence, how to prevent domestic violence within the family and how to keep the home safe. An officer from law enforcement will speak to participants on how to prevent violence in the home

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and how to protect themselves and their families from violence. Directors from the three sites will review the program along with two committee members with terminal degrees. The final program will be decided upon by the project team as a whole.

The interdisciplinary team after reviewing the literature, goals, and outcomes, will develop an educational program for displaced victims of domestic violence. The goal of this scholarly project was to improve the health and quality of life for these victims by screening for domestic violence and provide ongoing health education to empower this population. The interdisciplinary team fully understood the cycle of abuse which is illustrated by the Domestic Violence Power and Control Wheel. The team will have a complete understanding of the federal, state, and community licensing requirements for the program. Project team members will have the required credentials to start the domestic violence program.

Families caught in domestic violence need to seek help from professionals who are knowledgeable about the dynamics of domestic violence. Even if a domestic violence incident occurred only once, the likelihood of violence occurring again is extremely high. Gaining skills to better understand how to stop the cycle of violence in relationships is critical for everyone. It is time to end domestic violence and this educational program will achieve that goal.

## Target Population

The target population for this study will be women, men, and girls aged 18 and up who have been victims of domestic violence in the urban Southeast Florida Region. This specific population is housed at three different sites, all in Broward and Miami-Dade

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counties. The intent was to develop this program for implementation at three different sites. The first is a structured, comprehensive residential substance abuse treatment program for women, pregnant women, and women with children up to age five. These clients had issues with domestic violence, psychiatric problems, and issues with births of substance exposed newborns. This site has a capacity for 40 residents. The population in this area of Miami is underserved.

The second site is a recovery center that enhanced the lives of women with children who have issues with domestic violence and suffers from substance addiction. This 5 acre campus includes 40 apartments and serves 60 families. A child care center and an administrative/treatment facility are located on this campus. The third site is an outreach center for women and children. This center provides services for 50 women, children, and families. Participants chosen will be typical of the population, but individuals need not have experienced interpersonal violence to participate in this project. Existing evidence in the literature will be used along with practice expertise from the interdisciplinary project team.

**Develop Project Evaluation Plan**

In order to further develop and improve the educational program, a program evaluation plan, the post-then-pre method of self-report (Rockwell & Kohn, 1989) will be used. Traditionally, in the prepost design, participants must answer questions before the start of the educational program. Participants will be expected to participate in all phases of the lesson plan, and will be expected to answer more questions after the completion of the program. Information is collected with this type of evaluation before and after the

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program at the same time. Participants will be asked to rate their current knowledge at the end of the program on skill, attitude and behavior Now or After as a result of the program. Participants will be asked to reflect back and rate the same knowledge, skill, attitude, behavior Before participating in the program. According to Howard et al. (1979) and Howard (1980), response shift can mask program effectiveness. The post then pre design method can reduce or eliminate response shift bias. Rockwell and Kohn (1989) noted that when a response shift occurs, a different frame of understanding is used by the participant about a question between the pre and post periods. As a result, a problem is created when assessing self-reported change.

A survey type of method will be included at the end of the program to measure performance. Information about the program will be collected before and after the program, at the same time, using this method. By examining the results of the program, outcome evaluation can determine the reasons for deficiencies between outcomes, stated goals and objectives of the program. Program quality can be maintained or improved by reviewing the results of the program. The results of the program will determine if future planning can be more evidenced- based. Assessing the program's goal over a short-term period, the outcome evaluation method can be used. This method helps to determine how the program affects the outcome of the participants.

According to Hodges and Devito (2011), the implementation, effectiveness, efficiency, cost-effectiveness, and attribution ability of the program is based on program evaluation. The goal of this scholarly project was to improve the health and quality of life

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for victims of domestic violence by providing ongoing health education for empowerment of victims of domestic violence.

## Summary

Preventing domestic violence/intimate partner violence requires forward thinking, long term, and sustained efforts to achieve positive social change. The involvement of many sectors working together at community, national, and international levels is required. As Heise and Garcia-Moreno (2002) noted, responses at each level must include empowering women and girls, reaching out to men, providing for the needs of victims, and increasing the penalties for abusers. These goals and strategies together will help to build a comprehensive prevention program for victims of domestic violence. The key to achieving global reductions in violence to intimate partners is the progress achieved in each of the levels of the SEM. Carretta (2008) noted that domestic violence was an unfortunate but omnipresent occurrence in United States society, and that health care professionals have a major responsibility to address the issue of violence against women. Nurses must take a more active role in efforts to develop health care planning, public policies, and community responses to violence.

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Section 4: Findings, Discussion, and Implications

Preventing domestic violence/intimate partner violence requires forward thinking, long term, and sustained efforts to achieve positive social change. The involvement of many sectors working together at community, national, and international levels is required. Families caught in domestic violence need to seek help from professionals who are knowledgeable about the dynamics of domestic violence. Even if a domestic violence incident occurred only once, the likelihood of violence occurring again is extremely high.

## Educational Program

The interdisciplinary project team clarified the purpose and quantifies realistic goals and objectives of the project with the development of appropriate goals, objectives, and outcomes for the project. This helped to increase the effectiveness of the planning, implementation, and evaluation process. The goals directed the overall intent and lead to the desired outcomes of the project.

Outcomes, such as an increase in awareness and understanding of domestic violence, and how it affects people at home, and an increase in opportunities for participants to access resources and motivate participants to get involve and become part of the solution at work and in the community, were the proposed outcomes for the project. The project team and the community centers they represented aided in the development of the actual educational program. Strategies used include, educate the community, build support among key stakeholders for prevention efforts, develop programs that strengthen social networks, organize community groups to challenge social norms that contribute to the use of violence, and advocate for community accountability.

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The physician and the APN identified current facts from evidence-based literature on domestic violence. The officer from Law Enforcement spoke on how to keep communities safe. The minister from the local community church spoke to women and girls about domestic violence, how to prevent domestic violence within the family and how to keep the home safe.

## Implementation Plan

Implementation of the developed program started immediately at the three selected sites following IRB approval by Walden University. The purpose of this project was to organize and facilitate six community education sessions on domestic violence, with two classes at each of the three locations listed earlier in this project. The program implementation began with an introduction about the mission of the program, vision, goals and the objectives for each participant.

A total of 40 displaced victims were at all three centers and the interdisciplinary team was on hand to increase knowledge and awareness of violence, laws, and available resources. The physician and the APN identified current facts from evidence-based literature on domestic violence. The Officer from Law Enforcement spoke on how to keep communities safe. The minister from the local community church spoke to women and girls about domestic violence, how to prevent domestic violence within the family and how to keep the home safe. A 12-week domestic violence program for battered and displaced women was provided. Family members of the participants enrolled in the program were also offered education and services.

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Additionally, media outreach was provided to increase awareness about domestic violence. The program lasted for one hour and forty-five minutes with a 10- minute break after each 30-minute. At the end of the program, participants were asked to fill out a one-page evaluation tool consisting of 10 questions to produce meaningful results that were used to improve the program. Upon completion of a series of informative sessions through the educational program, in conjunction with group support and family counseling, the recurrence rate of domestic violence within the community decreased significantly.

## Evaluation Plan

In order to further develop and improve the educational program, a program evaluation plan, the post-then-pre method of self-report (Rockwell & Kohn, 1989) will be used. Traditionally, in the prepost design participants must answer questions before the start of the educational program. Participants will be expected to participate in all phases of the lesson plan, and will be expected to answer more questions after the completion of the program. Information is collected with this type of evaluation before and after the program at the same time. Participants will be asked to rate their current knowledge at the end of the program on skill, attitude and behavior Now or After as a result of the program. Participants will be asked to reflect back and rate the same knowledge, skill, attitude, behavior Before participating in the program. According to Howard et al. (1979) and Howard (1980) research showed that response shift can mask program effectiveness. Additionally, this design method can reduce or eliminate response shift bias. Rockwell and Kohn (1989) noted that when a response shift occurs, a different frame of

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understanding is used by the participant about a question between the pre and post periods. As a result, a problem is created when assessing self-reported change.

A survey type of method will be included at the end of the program to measure performance. Information about the program will be collected before and after the program, at the same time, using this method. By examining the results of the program, outcome evaluation can determine the reasons for deficiencies between outcomes, stated goals and objectives of the program. Program quality can be maintained or improved by reviewing the results of the program. The results of the program will determine if future planning can be more evidenced- based. Additionally, assessing the program's goal over a short-term period, the outcome evaluation method can be used. This method helps to determine how the program affects the outcome of the participants.

According to Hodges and Devito (2011), program evaluation looked at the implementation, effectiveness, efficiency, cost-effectiveness, and attribution ability of the program. The goal of this scholarly project was to improve the health and quality of life for victims of domestic violence by providing ongoing health education for empowerment of victims of domestic violence.

**Discussion of Findings in the Context of Literature**

Gaining skills to better understand how to stop the cycle of violence in relationships is critical for everyone. Heise and Garcia-Moreno (2002) noted that responses at each level must include empowering women and girls, reaching out to men, providing for the needs of victims, and increasing the penalties for abusers. These goals and strategies together helped to build a comprehensive prevention program for victims

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of domestic violence. The key to achieving global reductions in violence to intimate partners is the progress achieved in each of the levels of the SEM. Nurses must take a more active role in efforts to develop health care planning, public policies, and community responses to violence.

The evidence-based literature review with the project team helped to identify needs related to the program. The review included investigation of socioeconomic disadvantages associated with a range of psychological problems, such as lack of self-esteem or self-respect, powerlessness, frustration, and shame felt by displaced victims of domestic violence. Members from each discipline examined the literature on domestic violence from their perspective and made contributions from their own experiences as project team members, and the results were used to structure the project.

## Implications

Successful change requires going below the waterline, and because structure influences behavior, the only way to truly change behavior within the system is to identify, target, and change the underlying structures (Kelly, 2011). The problem must be thoroughly studied and analyzed. One should develop a clear understanding of the type, size, and scope of the problem. Problem analysis should focus on understanding the problem, not on generating the solutions (Ketter, Moroney, & Martin, 2008). There were several ways in which my educational program made a difference on society. Battered and displaced women and children were empowered by federal legislation such as the VAWA.

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The program alert and educates the public on how to recognize domestic violence and what to do about it; on teen dating violence; on the impact of family violence on children; and on domestic violence against the disabled and the elderly and other marginalized populations. The program promotes partnerships with corporations and foundations to design and fund more innovative programs to eliminate domestic violence and to foster development of safe alternatives within local communities. Victims are aware of the national Directory of Domestic Violence Programs. This directory provides up-to-date information about domestic violence programs throughout the country. Advocates and others in the domestic violence field have the knowledge on how to start, maintain, and structure financial education programs within their own communities to provide battered and displaced victims of domestic violence with better financial information to help them remain free from their abuser (Shepard, 2008).

Participants of an educational program for displaced victims of domestic violence and their families were provided with information about domestic violence, safe/confidential ways to seek assistance, rights as co-habiting intimate partners, and the resources available to them. A variety of services, not limited to crisis intervention, such as assistance in securing medical treatment for injuries, and information on legal rights were also provided. Support groups were conducted and referrals made to other partnering agencies. Domestic violence prevention was promoted through community outreach and education. Educational classes were conducted on the prevention of domestic violence and on skills necessary to enhance relationships. According to Shepard (2008), mobilizing communities to prevent domestic violence involves engaging

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communities in supporting, and implementing prevention strategies that target change in individuals, as well as in the community and society. Strategies included, educating the community, building support among key stakeholders for prevention efforts, developing programs that strengthen social networks, organizing community groups to challenge social norms that contribute to the use of violence, and advocating for community accountability. Community mobilizing strategies hold the potential for transforming those social norms and structures that are the root cause of domestic violence (Shepard, 2008). Research showed that many victims of domestic violence would not disclose the abuse unless they are directly asked or screened for domestic violence by the physician. It is imperative that health care providers directly inquire about possible domestic violence so victims receive proper treatment for injuries or illnesses and are offered further assistance for addressing the abuse.

## Project Strengths and Limitations

Silva (1981) defined assumptions as statements that are taken for granted or are considered true, even though they have not been scientifically tested. Theories and instruments are developed on the basis of assumptions that the researcher may or may not recognize. An assumption is that communities can develop more effective responses to violence if they have a common understanding of the causes of domestic violence. This common understanding helps victims avoid conflicting responses that could undermine efforts to protect them and hold batterers accountable (Minnesota Advocates For Human Rights, 2003). Another assumption is that by increasing knowledge about dealing with

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domestic violence, women with a history of domestic violence would use that knowledge to promote their own safety and health.

One limitation of this project is that it was often difficult to gather and collect all the data that were identified as being needed for evaluation of this program. Decisions about what data were essential and what data collection strategies were appropriate and available to the particular evaluation were made. A four-level Social-Ecological Model (SEM) was used to understand better and prevent violence. Limitation of biological and personal history factors such as age, education, income, substance abuse, or history of abuse, increased the likelihood of becoming a victim or perpetrator of violence. Close relationships that may increase the risk of experiencing violence as a victim or perpetrator is a limitation. A person's closest social circle-peers, partners, and family members influence their behavior and contribute to their range of experience. While evaluation planning was a part of this project, actual evaluation was taken at a later date.

**Doctors of Nurses in Practice and Domestic Violence Victims**

Connor et al (2013) looked at a large sample study, and noted that practicing nurses and physicians ($n$ = 925) with personal IPV experience were better prepared to inquire about violence and provide appropriate care. The researchers recommended that future researches continue quantifying and detailing IPV prevalence among this and other student health care profession populations. Other studies looked at by Conner et al, showed that students who were victims of IPV often encounter emotional stress, poor psychological and physiological health, and debilitating stress and anxiety that needed to be addressed through careful self-appraisal that includes seeking and receiving external

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validation of their experiences, feelings, and issues with confidence and self-esteem. As noted, these strategies will pave the way for identification and documentation of IPV in these student populations. Additionally, Conner noted that these strategies can also help facilitate perspectival and empathic pathways between students, the patients they encounter in their clinical experiences, and other colleagues who might also have been exposed to or directly experienced IPV.

According to Conner et al. (2013), some researchers suggested some students may be more receptive to change their practices than practitioners who were already established. Having a formal education will prepare health professionals with both the knowledge base and the skills necessary to adequately screen, intervene, or respond appropriately to persons affected by IPV. Others suggested that, whether nurses and nursing personnel have themselves experienced IPV, obtaining a sufficient educational foundation in IPV and continuing this education throughout their professional career will allow for a more caring attitude and skillful approach with colleagues as well as with patients. These areas were looked at for future studies; ramifications IPV has on educational and training efficacy of those professional nurses who engage in advanced research, public policy formation and health care delivery systems leadership.

Conner et al noted that evaluating health care systems where students will be working will help to determine what infrastructure changes needed to support institutional policy, protocols, public advocacy, and foundational research. These infrastructure changes as stated, will improve IPV screening, identification, management, and quality of care for this vulnerable population. A family violence curriculum entitled

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"Healing Homes" was pilot tested in a faith-based population. It utilized a "5R" (recognizing, responding, referral to resources, and being cognizant of mandated reporting requirements) approach in order to assess for, and respond to presentations of family violence across populations. Some researchers envisioned Healing Homes as a required course that will be fully integrated into the university graduate curriculum. As suggested, educating nursing students, particularly registered nurses and students in nursing graduate programs such as Doctor of Nursing Practice (DNP) or PhD, on these 5Rs is crucial to increasing knowledge of IPV (Conner et al, 2013).

**Health Care Reform and Domestic Violence**

Violence places an economic burden on the health care system and greater cost of its long-term health consequences. Domestic violence significantly increases the risk of negative health outcomes. Women who experience violence have more hospitalizations. Clinics, mental health facilities and out-of –pocket plan referrals are frequently used. According to Jewish Women International (2013), the health care system can adequately address domestic violence by:

1. Recognize the connection between serious health issues and exposure to violence
2. Conduct more research
3. Encourage health care providers to perform comprehensive health risks assessments including the screening of all patients for domestic violence
4. Establish guidelines to better address the treatment and management for patients exposed to domestic violence

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5. Ensure that all health professionals are adequately trained to assess and manage the care of victims of violence.

According to the Health Resource Center on Domestic Violence, Family Violence Prevention Fund (2010), health reform allows victims of domestic violence and abuse to have access to services that are affordable and easier to obtain that would treat their abuse and many of the resulting conditions of that abuse before they worsen. Victims of domestic violence were specifically included in several new protections and programs. The new law opened the door to integrating violence and abuse prevention into public health programs, research priorities, and adolescent health initiatives. As of January 2014, the new law prohibits insurance companies, health care providers, and health programs that receive federal financial assistance from denying coverage to women based on many factors, including being a survivor of domestic violence or sexual violence. Opportunities made possible by the Patient Protection and Affordable Care Act are as follows:

1. Prohibits pre-existing condition exclusion based on domestic violence history.
2. Maternal, infant, and early childhood visitation.
3. Preventing youth violence and reducing unintended pregnancies (Personal Responsibility Education Program).
4. Services for pregnant and parenting victims.
5. Native health.

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6. Potential additional opportunities to use health system to prevent intimate partner violence.

Quality Health Reform needs to adequately address the needs of women, but most of all, it must respond to the specific health care needs of victims of abuse and sexual assault (Jewish Women International, 2013).

## Analysis of Self

As scholar, as I reflect on the past 3 1/2 years of this DNP program, I realized that every class has meant continued growth both personally and professionally. I continue to develop my leadership, evidence-base practice and inter-professional collaboration skills. As I reflected on the literature review on domestic violence, I concluded that I have acquired a global perspective of victims of domestic violence, nursing practice towards victims of domestic violence, and healthcare cost for victims of domestic violence. I have used this knowledge to develop an educational program for victims of domestic violence.

As practitioner, I feel confident as a highly educated and qualified practitioner in my profession. I will apply my education and expertise in a leadership role such as teaching and research. I see myself as a change agent because personal mastery is to continually clarify, deepening one's personal vision, focusing energies, and developing patience. This educational program that I have developed effectively reduces risk factors and increases protective factors for displaced victims of domestic violence. Women and girls are empowered on services provided by many clinics, shelters, and nonprofit organizations. Displaced victims of domestic violence have access to information,

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education, and other necessary social and economic support to make informed decisions that best reflect their interests and needs.

As project developer, and a transformational leader, empowering team members involves getting the team to work together to achieve a shared goal. I realized how much my skills and knowledge have grown in leadership. Walden DNP program has prepared me to be a nurse leader and I have the responsibility of instilling the ideas of personal mastery in all my coworkers as a basis for shared vision and connections through the workplace. This DNP project aims to alert and educate the public on how to recognize domestic violence and what to do about it; on teen dating violence; on the impact of family violence on children; and on domestic violence against the disabled and the elderly and other marginalized populations. The aim of this project was to reduce domestic and family violence in new and emerging communities. This educational program increased the awareness, knowledge, and self-care agency of displaced victims of domestic violence. As for future professional development, the health and quality of life for victims of domestic violence could be improve by providing ongoing health education for empowerment of victims of domestic violence.

## Summary

Preventing domestic violence/intimate partner violence requires forward thinking, long term, and sustained efforts to achieve positive social change. The involvement of many sectors working together at community, national, and international levels is required. As Heise and Garcia-Moreno (2002) noted, responses at each level must include empowering women and girls, reaching out to men, providing for the needs of victims,

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and increasing the penalties for abusers. These goals and strategies together helped to build a comprehensive prevention program for victims of domestic violence. The key to achieving global reductions in violence to intimate partners is the progress achieved in each of these levels. Carretta (2008) noted that domestic violence is an unfortunate but omnipresent occurrence in United States society, and that health care professionals have a major responsibility to address the issue of violence against women. Additionally, nurses must take a more active role in efforts to develop health care planning, public policies, and community responses to violence. The positive social change implications for this study include educate and influence policy and decision makers about issues pertaining to domestic violence, organize events and campaigns to increase awareness of domestic violence and promote social change.

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Section 5: Manuscript for Publication

# Effects of Education on Victims of Domestic Violence

## Abstract

The purpose of this project was to improve support for victims of domestic violence. To that end, this project developed an evidence-based program to provide information about domestic violence including safe and confidential ways to seek assistance, rights as cohabiting intimate partners, and the resources available to community members. Several approaches were used to develop, validate, and plan for implementation and evaluation of this program, which was developed for 3 sites in Broward and Miami-Dade counties where the project is situated. The program logic model and the social ecological model, including the individual, relationship, community, and societal levels, were used to guide this project. In addition, scholarly works from 2000 to 2013 were selected from ProQuest, CINAHL, Ebscohost, Medline, and Ovid Nursing Journals to develop this program in collaboration with an interdisciplinary team of 7 community stakeholders including a physician, advanced practice nurse, law enforcement officer, pastor, and 3 recovery center directors with knowledge in these areas. Content validation involved incorporating feedback from the project team. The target population for the project includes women and men aged 18 or higher who have experienced domestic violence, homelessness, and drug addiction. Community operationalization of the initiative will be facilitated by implementation and evaluation plans developed as part of this project. The project includes community education that may help organize events and campaigns, increase

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domestic violence awareness among community members, and influence policy regarding issues pertaining to domestic violence.

## Problem Statement

Interpersonal violence toward women is a major health problem across the world and a major health care issue in the United States with 5.3 million incidents of interpersonal violence reported each year in the United States among women 18 years of age or older (Centers for Disease Control, 2011a). Hodges and Videto (2011) noted that the serious nature of interpersonal violence is a valid reason for human service professionals to investigate, develop, and implement programs for victims of violence. A group of researchers at Johns Hopkins Bayview Medical Center conducted a study in 1997 and found a link between childhood abuse and adult health problems (Doctor's Guide, 1995). One of the findings listed was that, "the least healthy group was the respondents who said they were abused as both children and adults; 50% of women abused as children were also abused as adults" (Doctor's Guide, 1995, p.2). Assessment for past sexual trauma, as well as for more recent or ongoing trauma such as domestic violence, is crucial to identifying and treating the trauma (Holland, Finger, & Carter, 2000). The problem addressed in the proposed project is the current need for an evidence-based program for displaced victims of domestic violence.

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## Purpose Statement and Objectives

An educational program, Partnership Against Domestic Violence (PADV; 2013), improved safety at home. The goal of the project was to develop an educational program that reduce risk factors effectively, and increase protective factors for victims of domestic violence. The intent was to teach women and men with a history of violence how to increase safety of the home and reduce risk of future violence. This educational program would be taught at three different sites.

The first site is a structured, comprehensive residential substance abuse treatment program for women, pregnant women, and women with children up to age 5. This site has a capacity of 40 residents. This site was chosen because of the issues amongst women and children with domestic violence, psychiatric problems, and issues with births of substance exposed newborns.

The second site is a recovery center, which enhances the lives of women with children who have issues with domestic violence, and suffer from substance addiction. This five-acre campus includes 40 apartments and serves 60 families. A child care center and an administrative/treatment facility are located on this campus. The third site is an outreach center for women and children. This center provides services for 50 women, children, and families. Counseling offered to those desiring to help bring about positive change in their lives.

## Project Goals

Project goals were carried out through collaboration with an interdisciplinary team comprised of health care professionals, a representative from each of the sites, and

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members from the community who showed interest in the program. Team members guided the development, implementation, and evaluation of the program. A 2-day domestic and family violence educational program was developed, along with plans for implementation and evaluation of the program. The aim of this project was to reduce domestic and family violence in new and emerging communities. This was done by increasing the awareness, knowledge, and self-care agency of displaced victims of domestic violence.

The project goals included:

1. A program for implementation at three different sites, all in Broward and Miami-Dade County that would provide information about domestic violence, safe/confidential ways to seek assistance, rights as cohabiting intimate partners, and the resources available to them.
2. Validate the program using scholars with expertise in the areas.
3. Implement the program.
4. Evaluate the program.

These goals assisted in the prevention of domestic violence through community outreach and education.

## Significance/Relevance to Practice

Laurence and Spalter-Roth (1996) reported cost estimates of $5 billion to $10 billion the United States spent annually for issues related to domestic violence. In the United States alone, the health-related costs of rape, physical assault, stalking, and homicide committed by intimate partner exceed $5.8 billion each year. Direct medical

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and mental health care services from that amount consumed nearly $4.1 billion, with $1.8 billion for the indirect costs of lost productivity or wages (CDC, National Center for Injury Prevention and Control, 2006, as cited in Carretta, 2008).

Consumers and providers alike are demanding cost containment. For all women, the advent of health-care reform is a victory. As for domestic violence victims, it is a lifeline (Rosenthal, 2010). Critics of the health care law have argued that it will be too expensive. Others say that by treating domestic violence early and aggressively money can be saved (Rosenthal, 2010). Intimate-partner violence costs the United States billions of dollars each year in lost workdays and expenses related to mental-health and substance abuse treatment (Rosenthal, 2010). A major change in the health care law is that women's domestic-violence insurance claims cannot be denied as part of a pre-existing condition. Health insurance companies can no longer designate interpersonal and domestic violence as a pre-existing condition as they have done in the past.

In order to improve preventive medical care, the Health-Care Reform Act (2010) stated that insurance companies can no longer charge for many basic screenings, including domestic violence screening. Rosenthal (2010) noted that domestic violence victims will not face gender discrimination or lifetime caps on benefits. Victims of domestic violence will not face the struggle of paying too much for health care while trying to rebuild their lives after suffering domestic violence. Now, victims of domestic violence need not be worried about access to health-care.

Funding from the government is approved and established to support the Violence Against Women Act (VAWA), legislation at the federal level, passed in 1994 and

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renewed every 5 years. Programs for reducing domestic violence are funded by VAWA (Foster, 2010). The Office on Violence against Women (OVW) (Foster, 2010) awarded more than $3 billion in grants to organizations to reduce domestic violence, dating violence, sexual violence, and stalking. Services to victims were strengthened by these grants and offenders held accountable (Foster, 2010). In Fiscal Year 2009, grants totaling more than $613 million were awarded by the OVW (Foster, 2010).

Radford and Gill (2006 as cited in Foster, 2010) looked at how cost and performance measures related to the impact of government policies on domestic violence in the United Kingdom focused on items that were easily measured. These items included the number of arrests for domestic violence and the number of domestic violence claims reported to police. West Virginia (WV) crime report statistics showed that the focus in the United States may be similarly skewed. The number of domestic violence incident investigations conducted by the WV police department increased over 1,000% from 1981 to 2005; also arrests increased nearly 3,000% (Foster, 2010).

Domestic violence has many other negative consequences for its victims. Physical health outcomes included injury (e.g., laceration, fractures, and internal organs injury), unwanted pregnancy, gynecological problems, and sexually-transmitted infections including HIV/AIDS. Other physical health outcomes included miscarriage, chronic pelvic pain, headaches, permanent disabilities, asthma, irritable bowel syndrome, and self-injurious behaviors, such as smoking and unprotected sexual activity (Carretta, 2008).

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Leserman (n.d.) explained how researchers looked at a large study of several primary care practices and compared women with childhood (no adulthood) sexual abuse ($n$ = 204) to those without abuse ($n$ = 1257) on many health status measures. The result showed that adult women who have experienced childhood sexual abuse were more likely to report abdominal pain (46% versus 28%), diarrhea (36% versus 24%), constipation (39% versus 27%), and pelvic pain (24% versus 11%) as compared to women without an abuse history.

## Evidence-Based Significance of the Project

Domestic violence has severe emotional and physical implications for women. Emotional health consequences of abuse include depression and post traumatic stress disorder, both of which fundamentally affect the quality of a woman's daily life and can require long-term counseling and group therapy to overcome. Women who experience abuse exhibit higher rates of substance abuse, suicide attempts, visits to the emergency department, and physical symptoms including poor appetite, bruising, vaginal discharge, abdominal and pelvic pain, diarrhea, breast pain, headaches, chest pain, dyspnea, and insomnia (Violence Against Women: Effects On Reproductive Health, 2002). Consequently, knowledge of domestic violence is important for clinicians.

Towsend (2012) looked at sociocultural theories as they related to societal influences. Towsend noted that although social scientists agreed that some biological and psychological aspects are influential, they concluded that aggressive behavior is primarily a product of one's cultural and social structure. Societal influences, as noted by Tardiff (2003), may contribute to violence when individuals realize their needs and desires are

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not being met relative to other people. As a result, with the limited access through legitimate channels, poor and oppressed people are more likely to resort to delinquent behaviors in an effort to obtain desired ends. This lack of opportunity and subsequent delinquency may somewhat contribute to a subculture of violence within a society.

The National Center for Health Statistics (2009) reported that with regard to ethnicity, statistics showed that White Americans were at the highest risk for suicide, followed by Native Americans, African Americans, Hispanic Americans, and Asian Americans. Anderson and Aviles (2006) cited Lee et al. (2002) African-American women and Hispanic women experience greater mental health consequences when they are victims of domestic violence. These women will be dealing with the stigma associated with domestic violence, and race, and the negative effects they have on the availability of and access to culturally-sensitive services (Lee et al. 2002).

According to Social Issue Report (2011), the Department of Justice most recent survey is listed that 1.9 million women are assaulted annually. The report listed 68% of women are abused by an intimate partner. Specifically, women of low socioeconomic status tended to experience domestic violence more frequently and more severely, while also having fewer resources and lacking access to services to protect themselves. Structural barriers such as poverty, low educational attainment, and lack of access to information make escaping violence more difficult as these barriers limit women's knowledge of available resources and their abilities to be financially independent. Anderson and Aviles (2006) reported that domestic violence is portrayed and perceived as a minority issue. Anderson and Aviles (2006) cited Martinson (2001), Weiss (2001),

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and Bograd (1999) domestic violence victims are routinely portrayed as poor women of color.

Anderson and Aviles (2006) cited Sullivan and Rumptz (1994) African American women were more likely to be living below the poverty level, to be the sole providers of their families, to have more children living with them, and to be less likely to have access to a car. On the other hand, Anderson and Aviles (2006) cited Menjivar and Salcido (2002) Hispanic women experience language barriers, isolation, lack of access to minimum wage jobs, and uncertain legal statuses.

Health care service providers perceive immigrant women as accepting of domestic violence because they believe that these immigrant women brought this belief and culture of acceptance with them. These women are more likely to lack a social network, making it easier for the abuser to isolate and control them. African American women do fear of being ostracized within their community for reporting abuse. Anderson and Aviles (2006) cited Martinson (2001) African American women may be viewed as contributing to the racial stereotypes and criminalization of the African American male.

Empowerment is the most effective approach to provide necessary services to victims (Social Issue Report, 2011). Empowerment theory underpins services provided by many clinics, shelters, and nonprofit organizations. With this approach, it is believed that victims of domestic violence should have access to information, education, and other necessary social and economic support to make informed decisions that best reflect their interests and needs. The empowerment approach uses knowledge dissemination, training, and counseling to create a set of services that victims control, such as post-victimization

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assistance and risk minimization (Social Issue Report, 2011). An educational program is needed in the community to empower displaced victims of domestic violence.

The CDC conducts research on violence, its causes, and effective prevention strategies. There are personal, peer, family, and social factors that may increase or reduce the chances that a person will become a victim or perpetrator of violence (CDC, 2011a).

## Implications for Social Change in Practice

Successful change requires going below the waterline, and because structure influences behavior, the only way to truly change behavior within the system is to identify, target, and change the underlying structures (Kelly, 2011). The problem must be thoroughly studied and analyzed. One should develop a clear understanding of the type, size, and scope of the problem. Problem analysis should focus on understanding the problem, not on generating the solutions (Ketter, Moroney, & Martin, 2008). There are several ways in which my educational program made a difference on society.

Battered and displaced women and children were empowered by federal legislation such as the Violence Against Women Act. The program alert and educate the public on how to recognize domestic violence and what to do about it; on teen dating violence; on the impact of family violence on children; and on domestic violence against the disabled and the elderly and other marginalized populations (Womenshealth.gov. 2011). The program promotes partnerships with corporations and foundations to design and fund more innovative programs to eliminate domestic violence and to foster development of safe alternatives within local communities (Partnerships Against Domestic Violence, 2013). Victims of domestic violence are aware of the national

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Directory of Domestic Violence Programs through Partnerships Against Domestic Violence (Partnerships Against Domestic Violence, 2013). This directory provides up-to-date information about domestic violence programs throughout the country (Partnerships Against Domestic Violence, 2013). Advocates and others in the domestic violence field have knowledge on how to start, maintain, and structure financial education programs within their own communities to provide battered and displaced victims of domestic violence with better financial information to help them remain free from their abuser.

Participants of an educational program for displaced victims of domestic violence and their families were provided with information about domestic violence, safe/confidential ways to seek assistance, rights as co-habiting intimate partners, and the resources available to them. A variety of services, not limited to crisis intervention, such as assistance in securing medical treatment for injuries, and information on legal rights were provided (Partnerships Against Domestic Violence, 2013). Support groups were conducted and referrals made to other partnering agencies (Partnerships Against Domestic Violence, 2013). Domestic violence prevention was promoted through community outreach and education. Educational classes were conducted on the prevention of domestic violence and on skills necessary to enhance relationships (Partnerships Against Domestic Violence, 2013). According to Shepard (2008), mobilizing communities to prevent domestic violence involves engaging communities in supporting, and implementing prevention strategies that target change in individuals, as well as in the community and society.

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Strategies include educating the community, building support among key stakeholders for prevention efforts, developing programs that strengthen social networks, organizing community groups to challenge social norms that contribute to the use of violence, and advocating for community accountability. Community mobilizing strategies hold the potential for transforming those social norms and structures that are the root cause of domestic violence (Shepard, 2008). Many victims of domestic violence would not disclose the abuse unless they are directly asked or screened for domestic violence by the physician. It is imperative that health care providers directly inquire about possible domestic violence so victims receive proper treatment for injuries or illnesses and are offered further assistance for addressing the abuse.

## Target Population

The target population for this study will be women, men, and girls aged 18 and up who have been victims of domestic violence in the urban Southeast Florida Region. This specific population is housed at three different sites, all in Broward and Miami-Dade counties. The intent was to develop this program for implementation at three different sites. The first is a structured, comprehensive residential substance abuse treatment program for women, pregnant women, and women with children up to age five. These clients had issues with domestic violence, psychiatric problems, and issues with births of substance exposed newborns. This site has a capacity for 40 residents. The population in this area of Miami is underserved.

The second site is a recovery center that enhanced the lives of women with children who have issues with domestic violence and suffers from substance addiction.

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This five- acre campus includes 40 apartments and serves 60 families. A child care center and an administrative/treatment facility are located on this campus. The third site is an outreach center for women and children. This center provides services for 50 women, children, and families. Participants chosen will be typical of the population, but individuals need not have experienced interpersonal violence to participate in this project. Existing evidence in the literature will be used along with practice expertise from the interdisciplinary project team.

## Definitions of Terms

*Affordable Care Act:* A federal statute signed into law in March 2010 as a part of the healthcare reform agenda of the US President Obama's administration. Signed under the title of the Patient Protection and Affordable Care Act, the law included multiple provisions that would take effect over a matter of year, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions (Whitehouse.gov, 2013).

*Delta*: The Domestic Violence Prevention Enhancement and Leadership through Alliances program seeks to reduce the incidence (i.e., number of new cases} of intimate partner violence (IPV) in funded communities. The program addresses the entire continuum of IPV from episodic violence to battering through a variety of activities (CDC, 2013).

*Interpersonal Violence:* Violence between individuals and is subdivided into *family and intimate partner violence* and *community violence.* The former category

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includes child maltreatment, intimate partner violence, and elder abuse, while the latter is broken down into acquaintance and stranger violence and includes youth violence; assault by strangers; violence related to property crimes; and violence in workplaces and other institutions (World Health Organization [WHO], 2013).

*IPV*: Intimate Partner Violence describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy (CDC, 2013).

*MAPP*: Mobilizing for Action through Planning and Partnership is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helped communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems (National Association of County & City Health Officials (NACCHO), 2013).

*NISVS:* National Intimate Partner and Sexual Violence Survey is a summary report presents data on the national prevalence of intimate partner violence (IPV), sexual violence (SV), and stalking among women and men in the United States (CDC, 2013).

*VAWA:* Violence Against Women Act of 1994 is a United States federal law. The Act provides $1.6 billion toward investigation and prosecution of violent crimes against women, imposes automatic and mandatory restitution on those convicted, and allows civil redress in cases prosecutors chose to leave un-prosecuted. The Act also establishes the Office on Violence Against Women within the Department of Justice. Its coverage

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extends to male victims of domestic violence, dating violence, sexual assault, and stalking (Violence Against Women Act of [1994], 1997).

*Displaced Victims of Domestic Violence*: Victims of domestic abuse have unmet needs for both short and long-term housing. Shelters provide immediate safety to battered/displaced women and their children and help them gain control over their lives. The provision of safe emergency shelter is a necessary first step in meeting the needs of women fleeing domestic violence (National Coalition for the Homeless, 2007).

## Project Strength and Limitations

An assumption is that communities can develop more effective responses to violence if they have a common understanding of the causes of domestic violence. This common understanding helps victims avoid conflicting responses that could undermine efforts to protect them and hold batterers accountable (Minnesota Advocates For Human Rights, 2003). Another assumption is that by increasing knowledge about dealing with domestic violence, women with a history of domestic violence will use that knowledge to promote their own safety and health. One limitation of this project is that it is often difficult to gather and collect all the data that are identified as being needed for evaluation of such a program. Decisions about what data are essential and what data collection strategies are appropriate and available to the particular evaluation will be made. A four-level social-ecological model (SEM) will be used to understand better and prevent violence. Limitation of biological and personal history factors such as age, education, income, substance abuse, or history of abuse, increase the likelihood of becoming a victim or perpetrator of violence. Close relationships that may increase the

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risk of experiencing violence as a victim or perpetrator is a limitation. A person's closest social circle-peers, partners, and family members-influences their behavior and contributes to their range of experience. While evaluation planning is a part of this project, actual evaluation will be undertaken at a later date.

**Doctors of Nurses in Practice and Domestic Violence Victims**

Connor et al. (2013) looked at a large sample study, and noted that practicing nurses and physicians ($n$ = 925) with personal IPV experience were better prepared to inquire about violence and provide appropriate care. The researchers recommended that future researches continue quantifying and detailing IPV prevalence among this and other student health care profession populations. Other studies looked at by Conner et al, showed that students who were victims of IPV often encounter emotional stress, poor psychological and physiological health, and debilitating stress and anxiety that needed to be addressed through careful self-appraisal that includes seeking and receiving external validation of their experiences, feelings, and issues with confidence and self-esteem. As noted, these strategies will pave the way for identification and documentation of IPV in these student populations. Additionally, Conner noted that these strategies can also help facilitate perspectives and empathic pathways between students, the patients they encounter in their clinical experiences, and other colleagues who might also have been exposed to or directly experienced IPV.

According to Conner et al, some researchers suggested some students may be more receptive to change their practices than practitioners who were already established. As noted, having a formal education will prepare health professionals with both the

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knowledge base and the skills necessary to adequately screen, intervene, or respond appropriately to persons affected by IPV. Others suggested that, whether nurses and nursing personnel have themselves experienced IPV, obtaining a sufficient educational foundation in IPV and continuing this education throughout their professional career will allow for a more caring attitude and skillful approach with colleagues as well as with patients. These areas were looked at for future studies; ramifications IPV has on educational and training efficacy of those professional nurses who engage in advanced research, public policy formation, and health care delivery systems leadership.

Conner et al noted that evaluating health care systems where students will be working will help to determine what infrastructure changes needed to support institutional policy, protocols, public advocacy, and foundational research. These infrastructure changes as stated, will improve IPV screening, identification, management, and quality of care for this vulnerable population. A family violence curriculum entitled "Healing Homes" was pilot tested in a faith-based population. It utilized a "5R" (recognizing, responding, referral to resources, and being cognizant of mandated reporting requirements) approach in order to assess for, and respond to presentations of family violence across populations. Some researchers envisioned Healing Homes as a required course that will be fully integrated into the university graduate curriculum. As suggested, educating nursing students, particularly registered nurses and students in nursing graduate programs such as Doctor of Nursing Practice (DNP) or PhD, on these 5Rs is crucial to increasing knowledge of IPV (Conner et al, 2013).

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**Health Care Reform and Domestic Violence**

Violence places an economic burden on the health care system and greater cost of its long-term health consequences. Domestic violence significantly increases the risk of negative health outcomes. Women who experience violence have more hospitalizations. Clinics, mental health facilities and out-of –pocket plan referrals are frequently used. According to Jewish Women International (2013), the health care system can adequately address domestic violence by:

1. Recognize the connection between serious health issues and exposure to violence.
2. Conduct more research.
3. Encourage health care providers to perform comprehensive health risks assessments including the screening of all patients for domestic violence.
4. Establish guidelines to better address the treatment and management for patients exposed to domestic violence.
5. Ensure that all health professionals are adequately trained to assess and manage the care of victims of violence.

According to the Health Resource Center on Domestic Violence, Family Violence Prevention Fund (2010), health reform allows victims of domestic violence and abuse to have access to services that are affordable and easier to obtain that would treat their abuse

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and many of the resulting conditions of that abuse before they worsen. Victims of domestic violence were specifically included in several new protections and programs. The new law opened the door to integrating violence and abuse prevention into public health programs, research priorities, and adolescent health initiatives. As of January 2014, the new law prohibits insurance companies, health care providers, and health programs that receive federal financial assistance from denying coverage to women based on many factors, including being a survivor of domestic violence or sexual violence. Opportunities made possible by the Patient Protection and Affordable Care Act are as follows:

1. Prohibits pre-existing condition exclusion based on domestic violence history.
2. Maternal, infant, and early childhood visitation.
3. Preventing youth violence and reducing unintended pregnancies (Personal Responsibility Education Program).
4. Services for pregnant and parenting victims.
5. Native health.
6. Potential additional opportunities to use health system to prevent intimate partner violence.

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Quality Health Reform needs to adequately address the needs of women, but most of all, it must respond to the specific health care needs of victims of abuse and sexual assault (Jewish Women International, 2013).

## Review of Scholarly Evidence

Literature specific to the project included a description of the Violence Against Women Act (VAWA). The program alert and educate the public on how to recognize domestic violence and what to do about it; on teen dating violence; on the impact of family violence on children; and on domestic violence against the disabled, the elderly, and other marginalize populations. Additionally, the program promoted partnerships with corporations and foundations to design and fund more innovative programs to eliminate domestic violence and to foster development of safe alternatives within local communities. Campbell et al. (2002) noted that a case-control study of enrollees in a multisite metropolitan health maintenance organization sampled 2,535 women enrollees aged 21 to 55 years. The study revealed that abused women have a 50% to 70% increase in gynecological, central nervous system, and stress-related problems. Routine universal screening and sensitive in depth assessment of women presenting with frequent gynecological, chronic stress- related, or central nervous system complaints are needed to support disclosure of domestic violence.

Zenilman and Shahmanesh (2012) cited Yudin and Wiesenfeld (2012, Chp. 16, p. 152.) approximately 44% of all women have been the victims of an actual attempted assault at some time in their lives. Women who have suffered abuse may account for 22% to 35% of women seeking care for any reason in an emergency department. An estimate

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of two million cases of domestic violence occur each year in the United States, and a previous study using population-based national samples, estimated that 60% of women have experienced at least one form of violence in their adult life.

Montero et al. (2011) noted the effect of different forms of interpersonal violence on women's health. A total of 10,815 adult women randomly sampled from primary health care services around Spain were included. There were four different categories. Thirty-seven percent of the women experienced lifetime violence. They concluded that the high prevalence of violence and its consistent association with a wide range of women's health problems suggested that violence seriously compromises women's health.

Ellsberg (2006) reported the results of the World Health Organization (WHO) study released in 2005. The study revealed that intimate partner violence (IPV) is common throughout all the sites studied, although considerable variation was found within and between countries. Between 15% and 71% of ever-partnered women had been physically or sexually assaulted by an intimate partner. Peterman, Palermo, and Bredenkamp (2011) reported for the Democratic Republic of Congo (DRC) Minister for Gender, Family, and Children who stated that more than one million of the country's women and girls are victims of sexual violence.

The United Nations of Population Fund revealed that 15,996 new cases of sexual violence were reported in the Democratic Republic of Congo (DRC) in 2008. Sixty-five percent of the victims were children and adolescents younger than 18 years, with 10% of all victims younger than 10 years. Despite the alleged severity of violence against women

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in the DRC, and the attention it has received in popular press, little research provides data-based estimates of the magnitude or nature of the problem. Reliable, nationally representative estimates of rape and sexual violence in the DRC do not exist (Peterman, Palermo, & Bredenkamp, 2011).

Campbell, Lichty, Sturza, and Raja (2006) examined the relationship between sexual assault and gynecological health symptoms such as pelvic pain and painful intercourse in a sample of predominantly African American female veterans. The study revealed that those who have been sexually victimized experience more frequent gynecological health symptoms than those who had not been assaulted. The recommendation was that women be screened in health care facilities for a history of violence; that way, they would be able to refer victims to resources and treatment for assault-related health symptoms.

Carretta (2008) noted that according to researchers, domestic violence had many other negative consequences for its victims. Physical health outcomes included (e.g. lacerations, fractures, and internal organs injury), unwanted pregnancy, gynecological problems, and sexually transmitted infections including HIV/AIDS. Other physical health outcomes included miscarriage, chronic pelvic pain, headaches, permanent disabilities, asthma, irritable bowel syndrome, and self-injurious behaviors, such as smoking and unprotected sexual activity.

Montero et al. (2011) noted that many studies examined the health consequences of violence by an intimate partner (IVP), as it was the most prevalent type of violence against women on a worldwide scale. But despite the significance of violence against

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women as a public health problem, few studies examined the health impact of violence perpetrated by persons other than intimate partners.

Lathe, Mignini, Gray, Hills, & Khan (2006) reported that several gynecological factors were strongly associated with chronic pelvic pain. A comprehensive review evaluated over 60 risk factors in 122 studies and found strong and consistent association between chronic pelvic pain and presence of pelvic pathology, history of abuse, and coexistent psychological morbidity. These key gynecological and psychosocial factors provided potential targets for new therapeutic strategies for treating women with this disabling condition, for which current treatment options provide little relief.

Chronic pelvic pain is seldom caused by a single factor alone. Lathe et al. (2006) argued that abuse was strongly associated with depression in women so it was possible that women who were abused were depressed. As a result they complained of chronic pelvic pain more often. Additionally, the association between abuse, psychological morbidity and pathology, and chronic pelvic pain were sufficiently consistent and strong to suggest that they may well be casually related.

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## Approach

There is a growing awareness that communities themselves must take responsibility for preventing and aiding victims of domestic violence by establishing programs and services that meet the needs of their citizens. Domestic violence is a widespread social problem that is recognized by society as no longer a private matter. Although women can be violent in relationships with men and violence is also found in same-sex partnerships, the over-whelming health burden of partner violence is borne by women at the hands of men (WHO, 2002).

## Project Design/Methods

The interdisciplinary project team clarified the purpose and quantified realistic goals and objectives of the project with the development of appropriate goals, objectives, and outcomes for the project. This helped to increase the effectiveness of the planning, implementation, and evaluation process. The goals directed the overall intent and lead to the desired outcomes of the project. Increase in awareness and understanding of domestic violence, and how it affects people at home, and an increase in opportunities for participants to access resources and motivate participants to get involve and become part of the solution at work and in the community, were outcomes for the project. The project team and the community centers they represented aided in the development of the actual educational program. Strategies that were used include educating the community, building support among key stakeholders for prevention efforts, developing programs that strengthen social networks, organizing community groups to challenge social norms that contribute to the use of violence, and advocating for community accountability. The

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physician and the Advanced Practice Nurse (APN) identified current facts from evidence-based literature on domestic violence. The Officer from Law Enforcement spoke on how to keep communities safe. The minister from the local community church spoke to women and girls about domestic violence, how to prevent domestic violence within the family and how to keep the home safe. Community mobilizing strategies hold the potential for transforming those social norms and structures that are the root cause of domestic violence (Shepard, 2008).

Given the stated problem addressed in the project, an educational program was developed for later implementation to help meet the educational needs of displaced victims of domestic violence. This educational program for these displaced victims was based on evidence from the literature. The long-term goal of the project was to develop a program that would reduce risk effectively and increase protection for victims of domestic violence. The target population for this project included individuals with a history of being victims of domestic violence and who currently receive services from the three sites selected for this project.

Given the stated purpose of the project, the following steps were taken: Obtain IRB approval, assemble an interdisciplinary project team, lead the project team in reviewing the evidence-based literature, define goals and outcomes, develop an educational program, validate content/delivery of program, develop an implementation plan and process, and develop a long-term evaluation plan for the educational program. The final product associated with this project was an implementation-ready, validated educational program, including implementation and evaluation plans. Should the

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community decided to implement the program, they would have a turn-key program customized to their community, constituencies, and population.

## Summary

Preventing domestic violence/intimate partner violence requires forward thinking, long term, and sustained efforts to achieve positive social change. The involvement of many sectors working together at community, national, and international levels is required. As Heise and Garcia-Moreno (2002) noted, responses at each level must include empowering women and girls, reaching out to men, providing for the needs of victims, and increasing the penalties for abusers. These goals and strategies together helped to build a comprehensive prevention program for victims of domestic violence. The key to achieving global reductions in violence to intimate partners is the progress achieved in each of these levels. Carretta (2008) noted that domestic violence is an unfortunate but omnipresent occurrence in United States society, and that health care professionals have a major responsibility to address the issue of violence against women. Additionally, nurses must take a more active role in efforts to develop health care planning, public policies, and community responses to violence.

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**Appendix A**

Mission, Vision, Goals, and Participants Objectives

| | |
|---|---|
| Mission Statement | To inform and educate women and girls with a history of violence or who have been at risk for domestic violence how to increase safety of the home and reduce risk of future violence in order to promote a healthy lifestyle both physically and mentally. |
| Vision | Increasing the awareness, knowledge, and self-care agency of displaced victims of domestic violence. |
| Program Goals | 1. Participants will verbalize an understanding of domestic violence and its consequences.<br>2. Participants will discuss modifiable and non-modifiable risk factors related to domestic violence.<br>3. Participants will be educated on how to recognize domestic violence and what to do about it.<br>4. Participants will be aware of the National Directory of Domestic Violence Programs throughout the country.<br>5. Participants and their families will be provided with information about domestic violence, safe/confidential ways to seek assistance, rights as co-habiting intimate partners, and resources available to them. |
| | 1. Recognize domestic violence and what to do about it. |

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| | |
|---|---|
| Participant Objectives | 2. Identify risk and protective factors of domestic violence.<br>3. Knowledgeable on how to increase safety of the house and reduce risk of future violence.<br>4. Identify biological and personal history factors that increase the likelihood of becoming a victim of domestic violence.<br>5. Examine close relationships that may increase the risk of experiencing violence as a victim or perpetrator. |

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## Appendix B

Educational Program

Education for Victims of Domestic Violence

Moderator/Organizer: Julette Anderson MSN/Ed

Presenters: Emergency Department Physician

Advanced Registered Nurse Practitioner (ARNP)

Law Enforcement Officer

Pastor, Local Community Church

Director #1, Recovery Center

Director #2, Recovery Center

Director #3, Recovery/ Outreach Center

Community Member

Objectives: Upon completion of the program the participants will:

1. Empowerment with necessary services such as clinics, shelters, and non-profit organizations.
2. Access information, education, and other necessary social and economic support to make informed decisions that best reflect their interests and needs.
3. Identification of risk and protective factors of domestic violence.
4. Knowledgeable on how to increase safety of the house and reduce risk of future violence.

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5. Identify biological and personal history factors that increase the likelihood of becoming a victim of domestic violence.
6. Examine close relationships that may increase the risk of experiencing violence as a victim or perpetrator.

General Information:

- Participation is optional.
- The participant is encourage but not required to stay for the entire program.
- The program will run for 1- 3/4 hours for 12 weeks on Thursdays, Fridays, and Saturdays. The program will be offered three times per year.
- Information shared in this program is confidential.
- Participants will be asked to complete a short evaluation survey at the end of the program.
- Refreshments will be served.

Program:

Introduction and Welcome- **Moderator**

**1.** Introduction of the interdisciplinary project team

a. Role of the team and its members

i. Emergency Department Physician

ii. Advanced Registered Nurse Practitioner ( ARNP)

iii. Law Enforcement Officer

iv. Director #1, Recovery Center

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v. Director #2, Recovery Center

vi. Director #3, Recovery/Outreach Center

vii. Pastor, Local Community Church

viii. Community Member

b. Short background on project development

c. Mission, Vision, and Goals of the project

**Part 1**

1. Domestic Violence Facts/Risks – **Advanced Registered Nurse Practitioner**

a. The Facts

i. Interpersonal violence (IPV) toward women is a major health problem across the world and a major health care issue in the United States.

ii. The United States reports 5.3 million incidents of IPV each year among women 18 years of age or older (CDC, 2011a).

a. Relevance and outcomes for participants
i. By the end of this program you will be able to answer these questions:
1. What is interpersonal violence?
2. What are the risk factors of domestic violence?
3. What have we learned?
4. Am I at risk?
5. How can I prevent it?

b. Define interpersonal violence?
i. Violence between individuals and is subdivided into family and intimate partner violence and community violence.

c. Am I at risk?
i. Several factors increase the risk for interpersonal violence.
1. Modified-controlled
a. Close relationship may increase the risk of experiencing violence as a victim or perpetrator.

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b. Schools, workplaces, and neighborhoods, in which social relationships occur are looked at to see if there is any association with becoming victims or perpetrators of violence.

2. Non-modifiable –uncontrolled
   a. Biological and personal history factors increases the likelihood of becoming a victim of domestic violence.
   b. Broad societal factors such as social and cultural norms are looked at to help create a climate in which violence is encouraged or inhibited.

ii. The more risk factors you have, the greater your chance of becoming a victim of domestic violence.

iii. It is important to implement programs and policies that reduce risk factors and increase protective factors at different levels in the Social-Ecological Model.

II. What is the Power and Control Wheel?

a. Behaviors abusers use to get and keep control in their relationships.
   1. Coercion and threat
   2. Intimidation
   3. Emotional abuse
   4. Isolation
   5. Minimizing, denying and blaming
   6. Children
   7. Male privilege
   8. Economic abuse

   If you or someone you know is experiencing these symptoms call 1-800-799-7233 or 1-800-787-3224 (TDD) (National Domestic Violence Hotline) or call 911.

**Part II**

1. Signs and Symptoms of Intimate Partner Violence – **Emergency Department Physician**
   a. The American College of Emergency Physicians (ACEP) encourages emergency personnel to assess patients for family violence in all its forms, including that directed toward children, elders, intimate partners, and other family members.

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i. Emergency physicians are familiar with signs and symptoms of intimate partner violence, child and elder maltreatment and neglect.
ii. Emergency medical services, medical schools, and emergency medicine residency curricula should include education and training in recognition, assessment and interventions in intimate partner violence, child and elder maltreatment and neglect.
iii. Hospitals and emergency departments (ED) are encouraged to participate in collaborative interdisciplinary approaches to detection, assessment and intervention for victims of family violence.
iv. Hospitals and EDs should maintain appropriate education regarding state legal requirements for reporting intimate partner violence, child and elder maltreatment.

**Part III**

1. Domestic Violence and Family Law **– Law Enforcement Officer**
   a. Domestic violence and family law includes orders of protection, confidentiality issues, safety plans, custody issues, financial issues, stalking, and sexual assault.
      i. Family legal advocates indicate that a parent who has committed an act of domestic violence may need to complete counseling prior to receiving visitation or custody. Custody court may enquire about domestic violence even if criminal charges are not pending.
      ii. Domestic violence Resource Center, one in four women has been a victim of domestic violence at some point in time.

**Part IV**

1. Substance Exposed Newborns/ Intimate Partner Violence – **Director #1, Recovery Center.**
   i. A structured, comprehensive residential substance abuse treatment facility.
      a. Assigned duties for each resident each week.
      b. Random urine testing
      c. Referral from the court system or walk-ins.
      d. Length of program depends on situation
   ii. Population underserved issues with domestic violence, psychiatric problems, and issues with births of substance-exposed newborns.

**Part V**

1. Career Training and Job Placement Assistance – **Director #2, Recovery Center.**

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i. Clients are put on a three -, six- or 12-month program track, where they are taught skills needed to successfully re-enter society.
   a. Caters to pregnant or parenting women and issues with domestic violence.
   b. Women are referred there by other agencies.
   c. Goal is to help women succeed.

**Part VI**

1. Empower homeless men, women and children to be productive members of society **–Director #3, Recovery/Outreach Center.**
   i. Transform lives of homeless men, women and children with substance abuse, domestic violence and mental health issues.
      a. Shelter, substance abuse treatment, education, computer literacy, job placement, healthcare, spiritual development and housing with Christian love, compassion and encouragement.
      b. How you can reduce hunger and homelessness.

1. Mobilizing Communities to Prevent Domestic Violence –**Pastor, Community Church.**
   i. Engaging communities in supporting, and implementing prevention strategies that target change in individuals, as well as in the community and society.
      a. Educating the community, building support among key stakeholders for prevention efforts.
      b. Organizing groups to challenge social norms that contribute to the use of violence.
      c. Advocating for community accountability.

**Part VII**

1. Reuniting Families, Restoring Lives, and Building New Futures – **Community Member.**
   i. Increasing knowledge about dealing with domestic violence, women with a history of domestic violence will use knowledge to promote their own safety and health.
      a. Organizing community groups
      b. Impact of family violence on children.

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**Part VIII**

1. Question & Answers/Wrap-up- Moderator
    a. Open microphone for participant's questions to the presenters and project team.
    b. Explanation and distribution of evaluation survey (Appendix E).
    c. Collect surveys, served refreshments, and thank you.

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## Appendix C

Implementation Plan

The program will be taught at three different sites in Broward and Miami Dade Counties on Fridays and Saturdays. The program will be held in the multi-purpose rooms of the three centers. The total capacity for each room is 60 but there will only be a total of 40 participants at all three centers. The program will last for 1-3/4 hours with a 10-minute break after each 30-minute.

The first part of the program includes welcome and introduction. Participants will be informed that participation is strictly voluntary and they are free to leave at any point during the presentation. Participants are also encouraged to stay for the entirety of the presentation. The program's mission and vision will be introduced along with participant's goals and objectives. This should take approximately five minutes. Next 20 minutes will be the Advanced Registered Nurse Practitioner (ARNP) with facts and statistics. Risk factors and the Power and Control Wheel were discussed. Questions are encouraged throughout the presentation.

The ED physician will spend 20 minutes discussing signs and symptoms of intimate partner violence. The law enforcement officer will discuss domestic violence and family law for 10 minutes. The Director for the Recovery Center in Miami will have 10 minutes to discuss substance exposed newborns and intimate partner violence. The Director for the Recovery Center in Broward, will have10 minutes to discuss career training and job placement assistance for domestic violence victims. The Director for

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other Recovery/ Outreach Center in Broward will have 10 minutes to discuss empower homeless men, women and children with issues with domestic violence to be productive members of society. The community member will have the next 10 minutes to speak on reuniting families, restoring lives and building new futures.

The project team will now gather to evaluate the success of the program after the second session. The presenters will provide input on what was effective and what could be done to improve the project. The program will be piloted during the month of August. The team will have discussion at the end of the second session on possible expansion of the program from three times per year to four times per year. Different grant programs will be looked at by the team to expand the program.

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## Appendix D

Project Evaluation Plan

In order to further develop and improve the educational program, a program evaluation plan, the "post-then-pre" method of self-report (Rockwell & Kohn, 1989) was used. Traditionally, in the pre - post design, participants must answer questions before the start of the educational program. Participants participated in all phases of the lesson plan, and answered more questions after the completion of the program. Information was collected with this type of evaluation before and after the program at the same time. Participants were asked to rate their current knowledge at the end of the program on skill, attitude and behavior *Now* or *After* as a result of the program. Participants were asked to reflect back and rate the same knowledge, skill, attitude, behavior *Before* participating in the program. According to Howard et al. (1979) and Howard (1980) research showed that response shift can mask program effectiveness. Additionally, the post - then – pre - design method can reduce or eliminate response shift bias. Rockwell and Kohn (1989) noted that when a response shift occurs, a different frame of understanding is used by the participant about a question between the pre and post periods. As a result, a problem is created when assessing self-reported change.

A survey type of method was included at the end of the program to measure performance. Information about the program was collected before and after the program, at the same time, using this method. By examining the results of the program, outcome evaluation can determine the reasons for deficiencies between outcomes, stated goals, and objectives of the program. Program quality can be maintained or improved by

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reviewing the results of the program. The results of the program determine if future planning can be more evidenced- based.

Additionally, assessing the program's goal over a short-term period, the outcome evaluation method can be used. This method helped to determine how the program affects the outcome of the participants.

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Goals, Outcomes and Evaluation Plan

| **Goal:** To reduce risk effectively and increase protection for victims at risk for domestic violence through the provision of an educational program. | | | | |
|---|---|---|---|---|
| Measurable Outcome(s) | Strategies | Timeline | Evaluation Measures | Staff Responsible |
| | | | | |
| Of the 40 participants who register for and complete the 12-week domestic violence education program activities 75% of participants will increase knowledge and awareness of violence, laws, and available resources. | Plan and provide six community education sessions on domestic violence three times per year. Provide within these sessions an interactive family discussion time. | August 2012 to June 2013 | -Pre and Post surveys<br>-Client satisfaction surveys. | Physician and APNs.<br>Law enforcement officer, minister from the community church, directors from each community sites, and members of the community who shows interest. |
| Of the 40 participants who register for and complete the 12-week domestic violence education program activities, 75% of participants will increase positive knowledge and awareness of violence, laws, and available resources by June 2013. | Weekly 1 ¾ hour domestic violence sessions for 12 weeks. Three sets of sessions will be offered during the year. Victims of domestic violence will learn how to increase safety of the home and reduce risk of future violence. | August 2012 to June 2013 | -Individual and family members assessment complete with each participant to determine identified strengths and needs.<br><br>-Pre-Post tests to determine lessons learned and increased knowledge and awareness of violence, laws, and available resources.<br><br>-Domestic violence victim satisfaction surveys. | Support Service, Job Trained Specialists, Domestic violence Volunteers. |

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## Appendix E

Evaluation Tool

The evaluation tool used for this project was the post-then-pre evaluation tool. Each question was answered on a scale of 1-4, with 1 being not much understanding, and 4 understanding a lot, with 2 and 3 somewhere in between. Learned behaviors by participants in the future were answered with a "yes or "no". This evaluation tool assisted the project team with presentations and also as a guide to improve outcomes.

Rockwell and Kohn (1989) explained how program participants have limited knowledge prior to participating in a program and cannot accurately assess their own current behaviors, therefore a "post then pre" evaluation should be considered at this time. Rockwell et al. stated that at the end of the program, participants' new understanding of the program content may have an impact on the responses on their self-assessment. The researcher explained that if a pretest was used at the beginning of the program, participants would have no way to correct an answer at the end of the program if they made an inaccurate assessment in the baseline data.

An evaluation problem is that a pretest taken at the beginning of an education program may be invalid because participants have limited knowledge in responding accurately to the questions being asked on the pretest. The post –then – pre design corrects the problem. The problem can be handled by not giving a pretest at the beginning of the program. At the end of the program, the participant answered two questions. The first question asked about behavior as a result of the program. This is the posttest

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question. Then the participant was asked to report what the behavior had been before the program. This second question was the pretest question, but it was asked after the program when the participant has sufficient knowledge to answer the question validly.

## Data Collection

Data collection is the process of gathering and measuring information in an established and systematic fashion that enables one to answer questions and evaluate outcomes. Accurate data collection is essential to answer questions about meeting the needs of the community. Comprehensive documentation of the collection process before, during and after the program is essential to preserving data integrity. Surveys will be carried out at one recovery center in Miami-Dade County and two recovery centers in Broward County to determine the lack of knowledge and its impact on the future of these victims. To get an adequate sample of the population, the surveys will be done over a 3-4 week period. It is necessary to inform participants of the purpose of the survey and that participation is optional. Additionally, participants will be informed that by not taking the survey it will not exclude them from participating in the program. Others methods that will be used to collect data is to hold community forums where everyone is invited to come and voice their opinions and experiences with domestic violence or IPV. Stakeholders in the community and law enforcement officials will be encouraged to attend this public forum to hear the concerns and needs of the community.

## Data Analysis

Data analysis will be performed as outlined in the evaluation plan. The Social-Ecological Model (SEM) (Appendix G) will be used to guide the project. The four levels

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of this model are: individual, relationship, community, and societal. The SEM is very useful in many ways. It allows one to address factors that put people at risk or protect them from experiencing or perpetrating violence (risk and protective factors), and the prevention strategies that can be used at each level to address these factors.

Stakeholders involved in the project, should have a role in interpreting the data. The data will be interpreted with the program's goals in mind. A limitation of the evaluation design which will be considered is possible biases and the validity and reliability of the results. Data analysis includes using a qualitative method to organize the data into segments where it can be examined based on the evidence-based literature and past research. An organized and logical approach will be used to gain meaning of this type of method. The process includes reviewing all surveys to get an overall sense of the data. The information will be placed into categories and identified. Next, the information will be coded, naming the focus area identified in a systematic manner. Common patterns will be identified across the coded data sets. Lastly, the data will be interpreted by returning to the outcomes for the project and evaluating whether the qualitative data collected and organized reflects the desired outcomes of the educational program.

The project team will gather to evaluate whether the program was a success. The program will be piloted during the month of August. The team will have discussion at the end of all program offerings on possible expansion of the program from three times per year to four times per year with longer evaluation plans. All input and discussion of data from other programs will help with the success of future programs. Additionally, different grant programs will be looked at by the team to expand the program.

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## Appendix F

Post-Then-Pre Evaluation Tool

To assess your understanding of domestic violence, please circle what you believe is your understanding of each area listed below. Now think back to before you started the program and circle whether you understood a lot (4), or not much (1), or somewhere in between.

| **What is your understanding of:** | **Now – After completing the program** | **Before-prior to participating in the project** | **I plan to continue to use these learned behaviors in the future** |
|---|---|---|---|
| 1. Domestic violence | 4 3 2 1 N/A | 4 3 2 1 | Yes No |
| 2. Modifiable and Non-modifiable risk factors | 4 3 2 1 N/A | 4 3 2 1 | Yes No |
| 3. Biological and personal history factors that increases the likelihood of becoming a victim of domestic violence. | 4 3 2 1 N/A | 4 3 2 1 | Yes No |
| 4. Support systems to foster development of safe alternatives within local communities. | 4 3 2 1 N/A | 4 3 2 1 | Yes No |
| **What is your ability to:** | | | |
| 1. Identify different phases of the Power and Control Wheel. | 4 3 2 1 N/A | 4 3 2 1 | Yes No |
| 2. Recognize signs of domestic violence | 4 3 2 1 N/A | 4 3 2 1 | Yes No |

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| | | | |
|---|---|---|---|
| 3. Identify risk related to age, education, income, substance use, or history of abuse. | 4 3 2 1 N/A | 4 3 2 1 | Yes No |
| 4. Implement education programs on domestic violence with the guidance of the interdisciplinary team to prevent domestic violence, which involves engaging communities in prevention strategies that target change in individuals, community and society. | 4 3 2 1 N/A | 4 3 2 1 | Yes No |
| 5. Involve family and caregivers to become active participants support. | 4 3 2 1 N/A | 4 3 2 1 | Yes No |

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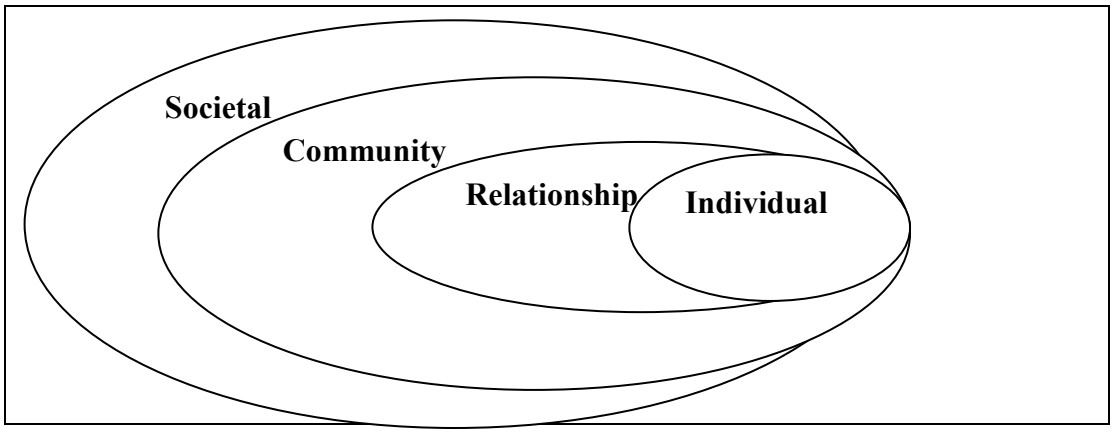
**Appendix G**

Social-Ecological Model




I. The first section is the *Individual level* which identifies biological and personal history factors that increases the likelihood of becoming a victim of domestic violence. The *Individual level* guided the project because it looked at factors such as age, education, income, substance use, or history of abuse. At this level, prevention strategies are designed to promote attitudes, beliefs, and behaviors that actually prevent violence.

II. The next level is *Relationship,* which examined close relationships that might increase the risk of experiencing violence as a victim or perpetrator. This level guided how data are collected from someone's closest social circle-peers, partners, and family members. Prevention strategies at this level would include mentoring and peer programs designed to reduce conflict, foster problem solving skills, and promote healthy relationships.

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III. Another level is *Community* which guided the project by exploring the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur. The characteristics of these settings were looked at to see if there was any association with becoming victims or perpetrators of violence.

IV. The *Societal* level is the final section of the framework and looked at broad societal factors such as social and cultural norms to help create a climate in which violence is encouraged or inhibited. Societal factors on a larger scale include health, economic, educational and social policies that can help to maintain economic or social inequalities between groups in society (CDC, 2009).

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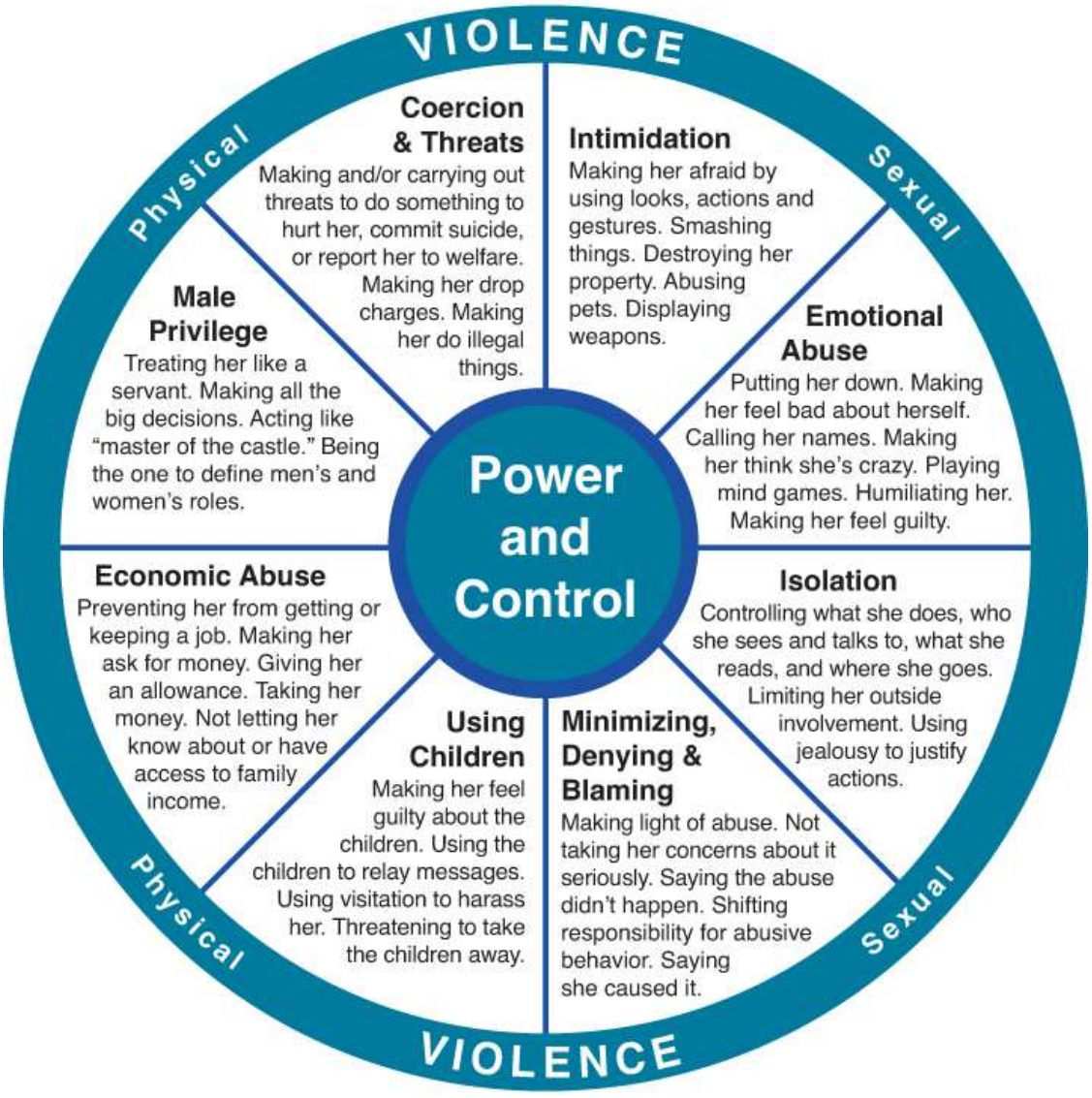
**Appendix H**

Domestic Violence Power and Control Wheel




Domestic Abuse Intervention Project www.duluth-model.org ... /

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## Appendix I

The Line-Item Budget to Implement an Educational Program

Revenues

| | |
|---|---|
| 1. United Way | 250,000.00 |
| 2. Contributions | 60,000.00 |
| 3. Special Events | 55,000.00 |
| 4. Other (Miscellaneous) | 20,000.00 |
| Total Revenues | $385,000.00 |

Expenses

| | | |
|---|---|---|
| 1. Salaries & Wages | | |
| Project Manager @ | 65,000.00 | |
| Secretary @ 25,000.00 (0.5 FTE) | 12,500.00 | |
| Social Worker @ 40,000.00 (0.5 FTE) | 20,000.00 | |
| Counselors @ 45,000.00 (0.5 FTE) | 22,500,00 | |
| Support Services Staff @ 24,000.00 (0.5 FTE) | 12,000.00 | |
| Educators 2 @ 72,000.00 (0.5 FTE) | 72,000.00 | |
| Job Training Specialists @ 30,000.00 (0.5 FTE) | 15,000.00 | |

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| | | |
|---|---|---|
| Total Salaries & Wages | $219,000.00 | |

| | |
|---|---|
| Employee Related Expenses (ERE) @ 25% | 22,300.00 |
| Rent (donated space at the local community center) | 0 |
| Utilities | 6,500.00 |
| Equipment (From donations) | 0 |
| Supplies (Some from donations) | 1,000.00 |
| Telephone | 6,500.00 |
| Other (Miscellaneous e.g. refreshments etc.) | 22,000.00 |
| Total Expenses | $385,000.00 |

**Appendix J**

The Program Development /Evaluation Cycle

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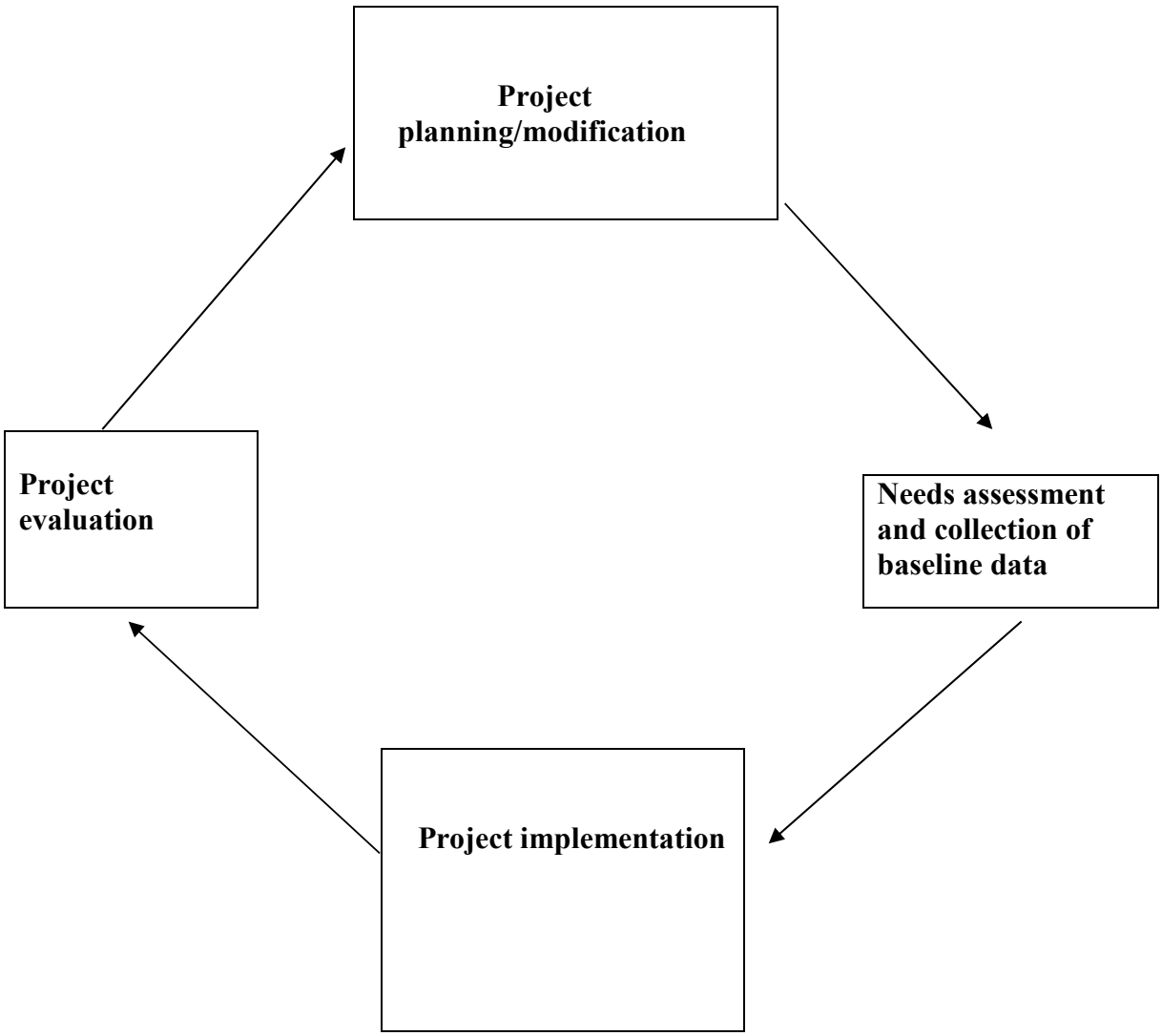


**Anderson, J. (2014). The Program Development/Evaluation Cycle.**

**Appendix K**

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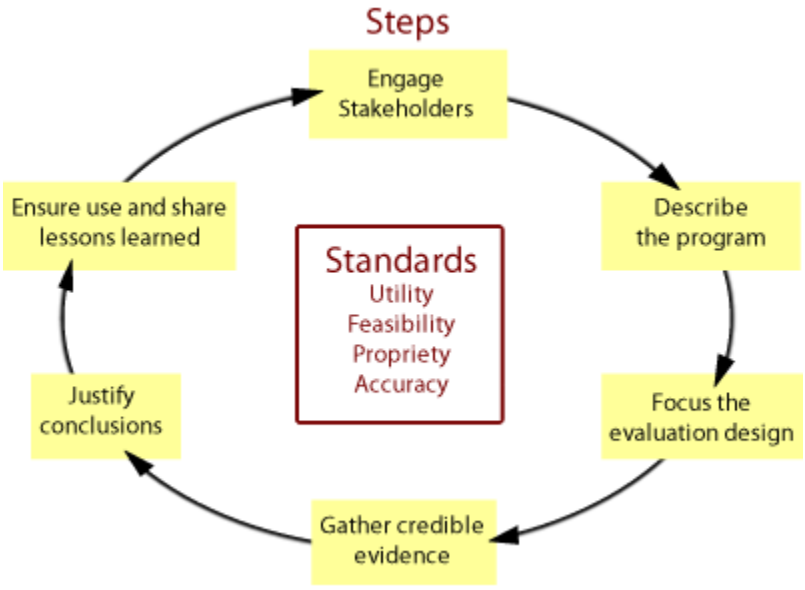
A Framework for Program Evaluation by CDC

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IRB Approval Letter

Dear Ms. Anderson,

This email is to notify you that the Institutional Review Board (IRB) has approved your application for the project entitled, "Education for Victims of Domestic Violence."

Your approval # is 02-26-14-0307637. You will need to reference this number in your doctoral project and in any future funding or publication submissions.

Your IRB approval expires on February 25, 2015. One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to extend your project beyond the approval expiration date.

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Curriculum Vitae

Julette N. Anderson MSN/Ed

**Current Position**

Adjunct/ Part-Time Clinical Faculty Instructor, Brown Mackie College, Miramar, FL

Adjunct/ Part-Time Clinical Faculty Instructor, Nova Southeastern University, Miami, FL

**Education**

2015 DNP Walden University, College of Nursing, Baltimore, MD

2011 MSN/Ed University of Phoenix, Phoenix, AZ

2009 RN/BSN University of Phoenix, Phoenix, AZ

1979 ADN Kentucky State University, Frankfort, KY

**DNP Project**

Education for Victims of Domestic Violence

**Professional Employment**

2014 –2015. Brown Mackie College, Miramar, FL

- Adjunct/Part-Time Clinical Faculty Instructor / Skills Lab Coordinator/Instructor

2012 –Present. Nova Southeastern University, Miami, FL

- Adjunct/Part-Time Clinical Faculty Instructor

2006 –2011. Jackson Health System, Miami, FL

- RN/Per Diem Staff Nurse Older Adult Medical, Surgical, Orthopedic, Neurology, Palliative Care Unit, and Diabetes Care Unit/Telemetry

2007 –2008. North Shore Medical Center, Miami, FL

- RN/Full Time Emergency Department

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2006 –2007. Aventura Hospital & Medical Center, Aventura, FL

- RN/Full Time Diabetes Care Unit/Telemetry.

**Professional Work Experience**

2004 –2006. Medical Staffing Network, Miami Lakes, FL

- RN/Full Time (contract) Jackson Health System North (formerly Parkway Regional Hospital).

2002 –2006. Catalanos Nurses Registry, Hialeah, FL

- RN Staff Relief Telemetry Unit

2001 – 2002. Hialeah Hospital, Hialeah, FL

- RN/Full Time Telemetry Unit & Emergency Department

2000 –2001. Memorial Regional Hospital, Hollywood, FL

- RN/Full Time Orthopedic/Neurology Unit

1999 –2000. Catalanos Nurses Registry, Hialeah, FL

- RN/Full Time Case Manager/On Site

1998 –1999. CAC United Insurance Company, Coral Gables, FL

- RN/Full Time Case Manager/On Site

1997 –1998. Comprehensive Medical Services, Miami, FL

- RN/Full Time Staff Relief

1996 –1997. Humana Health Plans, Miramar, FL

- RN/Nurse Reviewer/In House

1994 –1996. Comprehensive Medical Services, Miami, FL

- RN/ Full Time Home Health Field Supervisor

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1991 –1992. University of Miami (Inpatient Unit), Miami, FL

- RN/Full Time Medical/Surgical & Oncology unit

1991 - 1991. State of Florida, Department of Health & Rehabilitative Service, Lauderhill, FL

- RN/Full Time Public Health Nurse

1989 –1994. University of Miami (formerly Cedars Medical Center)

- RN/Full Time Medical-Surgical/Telemetry Unit, Neurology & Oncology Unit

1988 –1990. North Miami Hospital, North Miami, FL

- RN/Part Time Medical/Surgical Unit

1987 –1988. Comprehensive Medical Service, Miami, FL

- RN/Per Diem – Medical/Surgical Unit

1986 -1987. Miami General Hospital, North Miami, FL

- RN/Full Time Medical/Surgical Unit

1986 –1986. Baptist Hospital, Kendall, FL

- RN/Full Time Medical/Surgical Unit

1982- 1986. Veterans Administration Hospital & Medical Center, Louisville, KY

- RN/Full Time Medical/Surgical Unit

1981- 1982. Jewish Hospital, Louisville, KY

- RN/Full Time Medical/Surgical Unit

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**Professional Membership**

Sigma Theta Tau International Honor Society of Nursing

National League of Nursing

**Licensure/Certifications**

Registered Nurse – State of Florida (Active)

Registered Nurse – State of Kentucky (Inactive)

American Heart Association, ACLS & BLS

**Community Involvement**

Community Church

Ardenne Alumni Association (Miami Chapter)

Jamaica Nurses Association

Boys and Girls Club of Miami

**References**

Available upon request

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