

**Violence Intervention and
Prevention Program
Northeastern University**

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PROJECT OVERVIEW

Domestic violence is a serious public health problem. Latest estimates indicate that each year in the United States, one million women and 1.4 million children are assaulted by a family member. Nationwide, according to the National Crime Victimization Survey Report, “over two-thirds of violent victimizations against women were committed by someone known to them... and injuries occurred almost twice as frequently when the offender was an intimate (59%) than when a stranger (27%)” (Bachman, 1994).

In response to this public health problem, our Health Professions Schools in Service to the Nation (HPSISN) service-learning project Violence Intervention and Prevention (VIP) focused on initiating domestic violence education for health professions students and providing community service for agencies working with victims of violence. VIP sponsored curriculum development and implementation for nursing students at Northeastern University and public health students at Boston University. VIP also sponsored interdisciplinary staff development at six neighborhood health centers in Boston.

Project Goals

- Strengthen existing partnerships and build new linkages between community-based organizations and health professions schools;
- Enhance awareness of family violence and SL among community providers;
- Provide family violence prevention services to the community through SL projects developed and implemented by student advocacy teams;
- Increase knowledge of and skills in domestic violence for 25 health professions students in each year;
- Provide frequent opportunities for students to reflect on SL experiences, through an interdisciplinary seminar;
- Establish an advisory group;

- Develop a program infrastructure for the planning, coordination, and monitoring of the SL activities;
- Establish a program of faculty development;
- Integrate SL and content on family violence into the core courses of the professional schools; and
- Sustain the VIP project beyond the end of the grant funding.

SL Defined

SL is the unity between curriculum goals and community needs.

**Student, Faculty, and
Health Center Development**

During this three-year project, clinical practice guidelines were developed and standardized across the health centers. All staff members received training, and

family advocates placed at each site provided ongoing support. There also were interdisciplinary seminars for the students, led by medical, social service, and nursing staff, to better prepare the students to screen patients and intervene on behalf of victims of violence.

The Student Nurse Association also asked us to speak at their annual meeting and to act as their consultants for domestic violence education, as other colleges in the region did not offer this instruction.

Faculty development seminars also were held, and resource books and a video library were purchased to facilitate classroom and community educational efforts. We established a sexual assault prevention task force, which received extensive training in intervention strategies. The task force produced a guidebook that was distributed to all students and faculty; the guidebook's policies were implemented this year. Each year VIP has sponsored an educational session about date-rape prevention for Wellness Week on campus. This program has been very well attended by resident assistants, sorority members, and participants in the alcohol and drug counseling program.

The Advisory Board

The membership on the board includes representatives from the five community health centers, the medical and nursing schools, the staff educator at a battered women's shelter and advocacy program, the project evaluator, the project director, and the SL coordinator. As the project evolved, we included a

legislative liaison for policy advice.

The advisory committee met every month, in combination with the VOCA-funded Community Advocacy Program, which provided financial support for the family advocates. We had a combined agenda, and worked together to plan training sessions, community events, share resources, and develop the student experiences. Once the Center for Disease Control (CDC) grant was funded, the advocates' time was taken up with too many meetings. The board meetings were cut to every other month, but attendance fell. Missing a meeting meant that there was no contact for a quarter.

Funding Sources

The Violence Intervention and Prevention Project (VIP) received funding from several sources, including HPSISN. We were an outgrowth of the Kellogg-funded Community Partnerships Initiative, which promoted interdisciplinary community-based health professions education; it provided the infrastructure upon which VIP was built. The family advocates were funded by the Massachusetts Office of Victim Assistance, with increased support each year. Harvard Pilgrim Health Care Foundation funded the expansion project in year three, and the evaluation. We also participated in the CDC funding for the Dorchester Community Roundtable Initiative, and enjoyed the opportunity to meet with members of the criminal justice, religious, and social service communities through this grant.

PROJECT PERFORMANCE

Curricular Integration of SL

Through VIP, Boston University and Northeastern University instituted new courses on domestic violence. Both courses are at the graduate level, and have been taught by expert clinicians in the field of domestic violence. Only the Northeastern course integrated SL as a requirement.

University Curricula

Northeastern University

Nursing students were offered a three-credit theory/three-credit practicum course on domestic violence. The students' SL activities were in neighborhood health centers working with family advocates. The accompanying seminar provided the content about domestic violence and opportunities for analysis and reflection about their service. Because data indicate that one-third of all women have had personal experiences with violence, the faculty wanted to be aware of the students' experience; therefore, students interested in participating were asked to write an essay addressing this topic. During the class, family advocates and survivors of violence occasionally shared their experience.

The students kept reflective journals, which the faculty read and responded to weekly. Students who required more attention, due to their response to either their SL or personal experiences, meet with me in my office each week for debriefing. The family advocates also offered guidance and support to students who had experienced violence in their own lives.

As a response to what they had learned

in the domestic violence course, the nursing students requested a course on forensic nursing, which we developed and offered as a graduate elective.

Boston University

At the School of Public Health, the medical faculty offered a course on domestic violence. Students had the option of completing a paper or participating in a SL activity. All chose the paper.

Interdisciplinary Sessions

During the grant, we held interdisciplinary reflection seminars with the nursing and health professions students from the domestic violence courses. The nursing students, who were participating in SL activities, had far more to say about violence prevention. The public health students did not attend regularly. After the first year of the grant, these sessions were cancelled.

SL Activities

In the community, the SL activities have been diverse. During the three years of the grant, thirty graduate nursing students have spent forty hours each with the family advocates in the health centers or with other community agencies, such as the Child Witness to Violence Program at Boston Medical Center, or the Sexual Assault Nurse Examiner Program at the Department of Public Health. Throughout the curriculum, the students return to the same health centers; thus, they are able to commit to longitudinal projects in the communities. Many of these efforts involve violence prevention.

Establishing trust is ongoing work. It is not given easily, nor is it easily sustained. The confidentiality and the

privacy of the victims are closely guarded, for real safety reasons, and the students were not often given direct access to victims. There was concern about victims being used by the students or “re-victimized” by unskilled novices. Students had to work with the advocates for a term before any access to survivors was granted. The process was repeated each cycle, and some students did not get past the gatekeeping activities.

During the final year of the grant, placements were refused for VIP students due to changes in health center personnel, funding shifts, and an increase in students—more graduate students were going into the health centers for clinical experiences and the health centers could not accommodate them all. Placements were developed in expansion sites for the final year of the grant, and were funded with additional money from another grant proposal.

For VIP, students have:

- Initiated workshops, play groups for children affected by family violence, and support groups for victims and batterers.
- Developed and led health promotion seminars in schools, including topics such as conflict resolution and anger management;
- Collected information about community agencies to develop resource manuals, which subsequent students update.
- Worked on the development of the

health center protocols and agency policies.

- Created links with victim witness advocates at the courts, domestic violence officers at each police precinct, and members of the legal community through their activities, and have brought community people together to work on issues of violence prevention.
- Co-led support groups for victims or assisted with child care so that women could attend these meetings.
- Worked with advocates to organize health center trainings, develop brochures to advertise the program, place hotline and referral information in accessible areas in the health centers, and design bulletin boards and posters to raise awareness.
- Conducted their own research. One surveyed residents of battered women’s shelters to assess their health care needs and the screening practices of providers. Another developed a thesis that evaluated the effect of an educational intervention on the attitudes and beliefs of health care providers toward screening. Another assisted with the VIP program evaluation.
- Gathered data for a CDC-funded initiative for epidemiological data about domestic violence incidence and prevalence in Dorchester, with a comparison site in Lowell.

PROJECT ACHIEVEMENTS

While overall VIP has been very successful, the individual objectives have been met with varying degrees of success.

Strengthen and Build Community-Campus Partnerships.

This objective has been met through the interface with the criminal justice system. Although there have been differing perspectives about working

with victims of violence, the areas of intersection are much clearer in terms of roles and the need to collaborate. It has been challenging to work with members of the criminal justice system, but the opportunity to understand each other's roles has enabled us to make referrals that are more appropriate. The forensics course, requested by students, has taught us how to document injuries, take photographs, and protect specimens that may become evidence in court. Victim witness advocates have taken students into the courthouse to explain the process after a mandatory report of violence occurs from a health care provider.

Enhance Community Providers' Awareness of Domestic Violence and SL.

Through the family advocates, the health center staff received training, clinical practice guidelines, and resource materials. They came on campus to share their knowledge with other students. Student-initiated research has helped to improve practice patterns and increased the reporting of violence in the health centers. Since the students have brought their learning into their own communities and work settings, the scope of influence for this project has been expanded into the surrounding communities as well.

Provide Domestic Violence Prevention Services through SL.

Multiple projects have been initiated through the health centers, the schools, and the courts. The student teams were not as interdisciplinary as had been envisioned, however. The medical students were not often in the health centers at the same time as the nursing students and they were not required to perform a SL activity.

Increase Domestic Violence Knowledge and Skills of 25 Students Per Year.

This goal has been exceeded. There are between 20-25 students in each class at the medical school, which is offered three times per year. The nursing undergraduates range between 48-72 in each class, and seven classes are taught each quarter. The graduate students average ten per year per class, and 50% of them continue with their projects beyond the course through directed studies.

Provide Interdisciplinary Reflection on SL.

This objective was more challenging. The first year, we scheduled seminars every other week at the medical school. Although all of the nursing students attended, very few medical students did. In the second year, we scheduled enrichment sessions with guest speakers once a month and had a good response, but the numbers varied from ten nursing students to eighteen students across disciplines. Community members were invited to these sessions, but few attended. In the third year, we offered interdisciplinary training sessions and relied on the activities of the Dorchester Community Roundtable to bring folks together, which will be the ongoing mechanism for student involvement in interdisciplinary teams.

Establish an Advisory Group.

We established a group comprised of family advocates from each health center, their supervisors, and the nursing faculty teaching the courses. By the third year, participation declined greatly, due to other demands.

Develop Project Infrastructure.

In the grant, the positions of project evaluator and SL coordinator were developed, but there was not enough

money set aside in the budget to cover the demands of these roles. There was turnover every year in the coordinator position, and ultimately coordination fell to the project director. The project evaluator was very helpful, but also was not funded adequately.

Establish Faculty Development Programs.

Multiple faculty training sessions were held, including a faculty retreat. A video library and resource materials were purchased to aid in teaching. Faculty development also occurred in the connections that were made in the community as a result of this program. Faculty practice is improved through knowledge of referral sources and informal networks of community support. The faculty was introduced to colleagues across campus in criminal justice and the law school, and collegial relationships evolved through work on the university's Sexual Assault Prevention Committee.

Integrate SL and Domestic Violence Content into Core Courses.

Domestic violence has been integrated into the undergraduate and graduate curricula. SL and interdisciplinary community-based education has been implemented across the curriculum for the undergraduates and is beginning to be implemented in the graduate program.

Sustain the Project Beyond the End of Grant Funding.

Since the curriculum has been changed at both schools, the educational initiative will continue. The community-based SL opportunities will exist as there is continued funding for the family advocates and the need is great.

Student Development.

The success of VIP goes beyond

achieving the above goals. Students found their participation to be transformational.

Although it was a culture shock for some of these hospital-based clinicians to get acclimated to the health centers, they learned a lot about informal networks, community organizing, and the real barriers to accessing health care that exist in Boston. They also became very sensitized to the multidimensional problems of family violence and the need for an interdisciplinary team for intervention services. The criminal justice system, with lawyers, police, and court personnel, was a totally new language and experience for the students, and they became more aware of the different values and beliefs between the legal and health care systems. This exposure prompted them to request the forensics course, so that they could increase their knowledge and skills in terms of the medical/legal requirements of documentation, gathering and protecting evidence, and supporting victims of violence in the choices that they make.

The students became very invested in this issue. They wrote papers in other courses about domestic violence, and kept coming back to me for academic and professional guidance as they continued to pursue their service activities and this topic. Students wanted to work with the law school, and we had to get special course numbers assigned for their activities. Students became more involved with the medical students on individual projects. Based on their community experiences with the family advocates, the students were more sensitive to subtle cues that indicate possible abuse situations. Consequently, the students developed

supportive relationships with their peers, and extended themselves when other students were stressed. Violence prevention in the neighborhoods led to the development of a cadre of students who are more tolerant, caring, and less inclined to the horizontal violence that is often seen when students are in a highly competitive environment.

Some students have never left. Many have elected to continue their community service through directed studies or research practicum courses. The students either continue their roles with the family advocates, and become more actively involved with the victims of violence, or they develop their own areas of interest. One student wrote the Jane Doe admissions policy at Carney Hospital for victims of violence. Another student co-authored the grant proposal that allowed us to extend this work into another health center in East Boston. One student did the literature review for the CDC grant application, and another worked with Artists for Humanity to design book covers and key rings for high school students that helped to increase awareness of resources for victims of violence. Several of the students participated in the Dorchester Community Roundtable, and continue their involvement with their project groups, a year after completing the required coursework. One student

rewrote the play *The Yellow Dress* to fit into the class schedule of a parochial junior high, so that a barrier to its presentation could be overcome. Students initiated the forensics course and were involved in helping to recruit faculty to teach and students to take the course.

After graduation, many students have chosen to remain active in the domestic violence arena. They are truly committed to this issue, and it has changed the direction of their lives. They are applying the techniques that they have learned in the project to their own health care practices and continue to rely on their community contacts as they encounter clients or family members who are experiencing violence. Many have written practice protocols at their work sites and have offered training to their colleagues for screening victims. Many are actively involved with their communities, and are politically active with professional organizations. Several have been involved in the Domestic Violence Task Force of the State Nurses Association. The majority of the program graduates sit on task forces at work, and one student got her son involved—a high school teacher, he has begun a date rape prevention program for his students. Many have offered to work with future students as well.

COMMUNITY PARTNERSHIPS

Relationships with the community partners began tenuously and the goals of education and community service for health care professionals were difficult to achieve. The advocates were primarily survivors of violence and did not feel qualified to be preceptors. There was much support needed during

the first year, when they were funded for twenty hours a week, and the students were an additional responsibility. In the second year, the family advocates' hours were increased to full-time and it became easier to accommodate the students. However, their case loads were expanding rapidly and the role

demands became more complex. In the second year, the many meetings necessitated by the CDC grant were interfering with their ability to provide services to the clients, which is their primary role.

Domestic violence work is challenging, and there is a lot of job turnover among the advocates and staff involved in the

program. Working with survivors of violence has been a steep learning curve. When meeting one's basic living needs is a problem, it may be impossible to add another challenge such as the education of health professions students. After three years, we are a lot more sensitive to the issues, but have learned by making mistakes.

PROJECT EVALUATION

Evaluation of this project has been ongoing and process oriented. The weekly student logs and reflection seminars have been the most helpful in terms of immediate feedback, and the advisory board meetings have helped to modify or redesign the SL experiences. We also used evaluation tools developed by other HPSISN projects.

Instruments developed for the Learn and Serve Project tracked client contact, hours spent, and type of activity. These were less informative, because the students filled them out sporadically and many were incomplete. The students were required to complete forty hours of service for the course, and this is the number of hours that they documented. The reality was that many spent much more time. Richer information was obtained in the reflection groups.

We used an instrument developed by the San Diego HPSISN project to evaluate the impact of SL experiences on the students. The responses indicated that the students were very satisfied that the SL experiences were linked to classroom learning and they felt the experiences enhanced the coursework. They were less satisfied with some of the actual community experiences, as some wished to interact directly with victims of violence. The impact on the community

was more difficult for the students to assess, but they felt supported by the university in this project, and were satisfied with the agencies.

The SL evaluation packet, produced by the Portland State evaluation team, has been incorporated into the community classes. The concepts reflect my teaching style, and this instrument has been very useful as an evaluation of important behaviors. The results have been validating, more so than the forms used by the university. This year, colleagues used the forms in peer review, as well. The results will be helpful in preparing for tenure and in evaluating the effect of this experiential education.

When a survey was conducted in one health center to evaluate the impact of the training program, there were some very interesting results. Nearly one-third of the providers revealed that they had experienced violence in their own families, and that this had an effect on their practice. Before the training sessions, 39% indicated that they felt well prepared to intervene with victims of violence. After the training, this number increased to 69%. However, there were inconsistencies with the protocol implementation, and only 70% of the providers screened all clients. The

documentation of abuse and referral to social service agencies went down after the training. A retrospective record review of patient charts in urgent care revealed that more men than women were screened for violence, a reflection of the number of victims of urban street violence that seek help in the neighborhood health centers, instead of victims of domestic violence. This has implications for future training. The

data also reveal that education alone does not produce behavior changes in screening patterns. There must be infrastructure and ongoing support services for interventions to occur. Without the infrastructure, providers may be less likely to screen for violence, once they have been educated to all the complexities that domestic violence can present!

PROJECT SUSTAINABILITY

There is community and governmental support for violence prevention in the community. When President Clinton came to Boston to celebrate the lowered crime rate and congratulate the police and mayor for their efforts, it was very satisfying to be able to say, "We were also there in partnership with members of this community. We did not sit in the universities and teach about the statistics, we made an effort to change them." We all felt a part of the process, a part of the solution, instead of simply bemoaning the problem. This spirit will continue, as will the opportunities for involvement through the multiple sources of funding that have been obtained.

In the academic units, there are many changes. With funding for medical education in jeopardy, the medical school is in a continual crisis. Hospitals are merging, residencies have been cut drastically, and the health centers are overloaded with students. At Northeastern, the College of Nursing is merging with Bouve College of Health Professions. We have a new president, provost, and dean. With new leadership, there is not yet an indication that program development and evaluation or participative action research will be

valued in academic tenure decisions.

Although the structure is unclear, our commitment to the community and to community-based education has been affirmed as the cornerstone of our philosophy of education. Appreciating the value of experiential education and SL is the hallmark of this institution. These violence prevention efforts have expanded the arena in which we are educating students and provide a real service to the community.

An enormous amount of work has gone into capacity building and infrastructure for VIP. With frequent staffing changes and high levels of burnout, it is a process that needs to be continually repeated. Without a full-time coordinator, that level of intensity will not continue. What will continue will be individual efforts to maintain a presence in the health centers to work with the health center staff to understand the barriers to screening and intervention that continue to exist. In this way, we can continue to educate a new generation of health care providers who are able to intervene successfully with victims of violence. In working with a community nurse, and questioning her about family relations in one of her patients' homes, she said,

“Since taking this job, my margin of horror has increased.” She did not see a problem unless there was evidence of physical abuse. The rest she saw as “part of the urban reality.” This attitude

blinds health care providers to the needs of victims of violence, and demonstrates the imperative for continued educational efforts.

LESSONS LEARNED

- The budget is one area in which lessons were learned that will affect decision making on future grants. Since most of the grant money was allocated for training and health center expenses, there was not enough for faculty release time, which would have been helpful as the project evolved. Providing funding for students was a positive step, in that it encouraged their participation beyond the original coursework.
- Learning how to manage conflict, incorporate diverse perspectives into solutions, and hear other views has been a major undertaking. Knowing which battles to fight and which to concede has been helpful. Gaining a refined understanding of the concept of advocacy, in which clients are empowered to make their own decisions, instead of the Don Quixote approach of saving them from themselves, has changed the way collegial relationships are handled.
- If one-third of the female population have been victimized, then one may expect to encounter survivors among colleagues and in classrooms. This is an important point for faculty to consider when teaching about violence. In planning the project for survivors of violence, we did not include ourselves. We had not anticipated that talking about violence might initiate disclosures among our co-workers and students that would need to be addressed. One staff member who received training disclosed that she had been in an abusive

relationship, and that the training had given her the knowledge and strength to end it. Several students had this experience, as well. Although we were not entirely prepared, it was very helpful to be connected with experts in the field who were willing to be referral sources. Having a working relationship with counselors is important.

- The provider surveys indicated a prevalence of violence among health care workers. Can we really expect them to intervene effectively, when they may be in the same situation as the victim? This finding extends the theory of the cycle of violence into the work place, an area of research that adds to the complexities of screening and intervention.
- Part of the denial of the problem of violence in our society, apart from not seeing it in our peers, is that it is easier to screen clients who differ from us, by race, class, socioeconomic status, gender, religious preference, culture, or sexual preference. Victims will seek a safety zone, for physical, psychological, and emotional safety. Providers will do the same. Advocacy skills need to be taught, and practice opportunities need to be created safely in clinical settings.
- We also have discovered through research that education alone does not mean that providers will screen for violence. Less than 50% of the patients who presented at the clinic with injuries were screened for domestic violence.

Out of the patients who were screened, 52% were male. We concluded that while we were educating providers about relationship violence, the clients who were walking into the clinic were victims of urban street violence. We need to tailor our approaches to meet the needs of the patients that the clinicians are seeing.

- Another barrier to providing academic education in the area of domestic violence is that there is a lack of a theoretical base for the screening activities.
- One important lesson learned from working with victims is the need to identify patterns of victimization in our colleagues and students. The “victim mentality” has sensitized us to the power differentials that exist in the field, showing us the need to exercise caution in using this power inappropriately. This is one example of transformational experiences leading to changed priorities, community activism, and political engagement in this arena. The feminist notion of “giving voice” to the problems of domestic violence has required the courage to engage in an area

that the majority of the population prefer to keep hidden.

- The final lesson learned, from working with other disciplines, is how our perspectives and world view shape our perceptions and values. Where we sit determines where we stand on the issues that are important to us. The power and control that come into play when working on collaborative research projects and how we demonstrate respect for students, victims, members of other disciplines, and neighborhood residents have been amply demonstrated in the conduct of this project. The importance of ethical practice, in the context of the needs of the victims of violence, has been a motivating factor for the faculty and students involved in VIP. In the words of Socrates, “It is better to suffer evil than commit it, because the former only harms my body, but the latter corrupts my soul.” This motivates us to continue to find the courage and resources to confront the problems inherent in working with victims of violence in the neighborhoods, and not to be silent on their behalf.

References

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