

Summary and Conclusion

A number of tentative conclusions can be drawn based on the results reported in the various sections of this report. These results have also raised issues that may benefit from additional research. Tentative conclusions and ideas for further research, along with a summary of the limitations of the research reported previously, will be presented below.

Conclusions

Initially, this study indicated that DAIP staff could work with other professionals in the community to develop and implement an assessment protocol that would enable these professionals to identify a higher percentage of women who were experiencing domestic violence. The results reported in Section A indicated that EAP counselors significantly increased the percentage of women clients identified as experiencing domestic violence, increasing from 7% during the 1994 baseline year to 15-20% during 1997-98 when an assessment protocol was used. Results also indicated that public health nurses identified domestic violence at a rate 50% higher when an assessment protocol was regularly used than when it was not, but this difference was slightly below the level of significance adopted for this study. Comparison to criminal justice records indicated that some public health patients who were documented in the records as being victims of domestic violence were not identified during public health visits when the protocol was used. Both the public health nurses and EAP counselors reported that learning the protocol, using specific questions to screen for domestic violence, and training provided by DAIP were helpful.

The results of this study also indicated that DAIP staff could work with other professionals in the community to develop and implement an assessment protocol that would enable these professionals to refer a higher percentage of women to domestic violence services. Results reported in Section A indicated that public health nurses and EAP counselors were significantly more likely to provide information about services when the assessment protocol was used in 1996-98 than they were in 1994 before the protocol was implemented. Few women (less than 3%) were referred directly to domestic violence services in any years of the study, but public health nurses using the protocol in 1997 were significantly more likely to refer women directly to services than they were in 1994 before the protocol was implemented. Nurses and EAP counselors reported that the training and lists of resources from DAIP were helpful in implementing the protocol.

This study provided indication that the Enhanced Domestic Intervention Project (EDAIP) could result in lower rates of recidivism by offenders. The EDAIP enhanced the coordinated response by developing methods of risk assessment, implementing new sentencing recommendation procedures, developing a computerized information system to track and monitor domestic violence cases, and implementing an alternative men's non-violence program. The results reported in Section B indicated that recidivism rates at 6 and 12 months were lower in 1997 and 1998 when the EDAIP was implemented than in the 1994 baseline year.

The EDAIP did not lead to lower abuse, increased safety, and increased well being; these results are also reported in Section B. Abuse scores were significantly lower at the 18 month follow-up for women from 1994, 1996, and 1997, but there were no significant differences in change scores between the 1994 baseline year and 1996 and 1997 when EDAIP was implemented. A high percentage (72-82%) of women reported feeling safer at the 18 month follow-up, but there was no significant difference between years. Additionally, there were no differences in well being scores between the 1994 baseline years and 1996 and 1997 when EDAIP was implemented.

Several control variables were more related to outcomes than either the EDAIP or the alternative

men's program (see below). Men were less likely to recidivate if they were not court mandated and if they completed the nonviolence program. Women reported significantly greater reductions of physical abuse and total when men completed the program; women also reported greater reductions in psychological, physical, and total abuse when men were court mandated to the non-violence program. Batterer categories used by probation officers and the Men's Nonviolence Program were also related to recidivism, suggesting that the matrices are useful tools.

Women generally found community intervention to be more helpful than harmful. Based on their responses to the 18 month follow-up survey, a majority of women reported most elements of the community's intervention to be helpful rather than harmful. They found police intervention, obtaining an OFP, and services from the Women's Coalition to be most helpful. The Men's Nonviolence Program was viewed as the least helpful intervention. Some women reported that the system did not always follow through with enforcing consequences for offenders who continued to be violent.

The alternative men's program that incorporated community meetings, when compared to the men's programs that did not incorporate community meetings, did not lead to more positive outcomes. The results indicated no differences on measures of recidivism between the alternative men's program and the comparison programs. Data from 18 month follow-up surveys from domestic violence survivors indicated no differences on abuse, safety, or well being when comparing women whose partners attended the alternative program to women whose partners attended the comparison programs. The men in the alternative program were less likely to complete their program than the men in the comparison programs.

DAIP was able to work with professionals in three settings to develop assessments of dangerousness that identified risk factors that were associated with 1) the level of intervention in their setting and 2) specific program outcomes. Public health nurses used a higher level of intervention if the abuser showed no remorse and if the abuser was experiencing high stress. EAP counselors selected a higher level of response if the abuser seemed obsessed/preoccupied with the victim and if the abuser showed no remorse about what he had done. The DAIP advocate used a higher level of response if the victim had been trying to separate from the abuser in the last three months.

The assessments of dangerousness also included specific risk factors that were related to program outcomes. The offender was more likely to have recidivated after 6 months if the victim reported that the abuser had seriously injured the victim or the abuser had been assaulting the victim more frequently. Recidivism after 12 months and 18 months was more likely if the abuser had injured or killed a pet. Several abuse factors (abuser ever threatened or forced the victim to have sex, abuse getting more severe, abuser injured the victim so badly that medical attention was required, and abuser not threatening or trying to commit suicide) were associated with a higher abuse score reported by women on an 18 month follow-up survey. None of the risk factors were related to safety at the 18 month follow-up. Measures of well being were higher if the abuser had ever threatened or tried to commit suicide.

The risk factors that were associated with higher levels of intervention in the three settings were different than the risk factors that were associated with positive or negative program outcomes. For example, subsequent abuse scores reported by women were associated with four different risk factors, but none of these four factors was associated with a higher level of intervention for any of the professionals (counselors, nurses, or advocate).

Limitations

A number of limitations must be considered in examining the results and conclusions reported above. Non-equivalent comparison groups were used in Sections A, B, and part of C. Recidivism data relied on secondary data for which reliability could not be completely established, and measures of safety and well being did not have established reliability and validity. In several cases the independent variable was not fully implemented. The results and conclusions reported above and in the full report should be examined in light of these limitations and those reported near the end of the various sections.

Future research

The current studies also raised many important issues that should be considered in future research. In implementing an assessment protocol, researchers might examine what type of protocol is most effective in different settings and how to maximize and maintain the implementation of a protocol. Research might also examine why so few women may be directly referred to services in different settings.

Several components of the EDAIP were not fully implemented, and future research might examine how to maximize implementation of diverse components of a coordinated community response. The alternative men's program in this study was not associated with improved program outcomes; additional research might focus on how to effectively integrate the broader community into men's programs. The relation of several control variables to program outcomes suggests that future research might examine how to increase completion rates of programs, how to provide effective nonviolence programs for mandated as opposed to non-mandated offenders, and how to provide differential programs for offenders that fit into different batterer categories.

Results on risk factors also suggest future research possibilities. Many risk factors included in this study were unrelated to levels of intervention or a variety of program outcomes; if future research suggests that these risk factors are not associated with interventions or outcomes, perhaps these factors could be eliminated from assessments. In the current study, the factors that led to higher levels of intervention were not related to program outcomes, and vice versa. Future research might ask professionals to examine the factors that they use to determine a level of intervention and determine if these factors are related to particular outcomes.