Increasing Victim Safety and System Accountability: Evaluating a Collaborative Intervention Between Health Care and Criminal Justice

FINAL TECHNICAL REPORT
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An Epidemic with Few Tested Treatments

Violence against women largely involves intimate partners, such as husbands, boyfriends, and dates. A recent federal report estimates that 2.1 million women are physically or sexually assaulted each year (Tjaden & Thoennes, 1998). Of surveyed women who report rape or physical assault since the age of 18, most (75%) report victimization by a current or former spouse, cohabiting partner, or date.

The urgency and magnitude of the problem of intimate partner violence have caused service providers, policy makers, and advocates to implement treatment and intervention programs in the absence of scientific evidence (Chalk, 2000). The rush to do something has resulted in a broad array of interventions, many with origins in local and national advocacy efforts, such as shelters and social support programs, and as such remains mostly undocumented and unanalyzed in the research literature. Control or comparison groups are rare in family violence research and, if one exists, the sample is frequently too small for sufficient power to detect significant differences. To advance the science of family violence research, "Violence in Families: Assessing Prevention and Treatment Programs" (Chalk & King, 1998), a recent report on family violence prepared by the National Research Council and the Institute of Medicine, calls for the immediate collaboration of researchers with service providers toward the evaluation of interventions that are predicated in theory with critical components that can be measured. The purpose of this research is to increase victim safety and increase justice system efficiency with protection order processing by applying an advocacy-case management intervention. The

research is a collaborative effort between justice and health with registered nurses working with the justice system to test an intervention. The setting of this research is the District Attorney's Office in Houston Texas. The subjects were women who qualified for a civil protection order against a sexual intimate. The research goals and objectives are presented followed by the study methods, results, and implications for victim safety and justice system efficiency.

RESEARCH GOALS & OBJECTIVES

Increase Victim Safety

Women who experience intimate partner violence are at risk to minor and major physical and psychological trauma as well as potential femicide. Latest estimates from the National Crime Victimization Survey indicate that in 1998 half of the female victims of intimate partner violence reported a physical injury. About 4 in 10 of these women received medical health assistance (Rennison & Welchans, 2000). Therefore an intervention to increase women's safety could potentially prevent trauma and injury.

The specific victim outcome objective for this study is:

- More safety-seeking behaviors, lower experienced violence, higher physical and emotional functioning, and less employment harassment among women who qualify for a protection order and receive the Advocacy-Case Management intervention as compared to women who do not receive the intervention.

Increase Justice System Efficiency with Protection Orders

It is well documented that abused women often turn to the criminal justice system for protection. When Taylor (1995) surveyed 250 victims of domestic violence in New York City who had called 911 for help, the most common service sought (58.5 %) was help with securing a

protection order (PO). These victims view PO's as the preferable criminal justice alternative, that is, they often want to get a PO but do not want to file charges.

Furthermore, if a woman receives a protection order, several studies have demonstrated that the intimate partner violence decreases. Kaci (1994) found that, of the women who received a protection order, 87 percent responded at one month and 100 percent responded at four months that the protection order helped to stop the abuse. Keilitz and associates (1997) also found that the majority of women who received a protection order against their abuser reported no continuing problems at one month (72%) and at six months (65%). Ptacek (1999) reports some 86% of the women who received a protection order state the abuse either stopped or was greatly reduced. Gist and colleagues (2001a) also report that all the women in their study who received a protection order reported significantly less violence at one year following receipt of the protection order.

However, a six-month longitudinal study, found that among sixty-five abused African-American, White, Hispanic, and Asian women applying and qualifying for a protection order against a sexual intimate, only half of the women actually received the order (Gist et al., 2001b). Among the women who qualified but did not receive the protection order, most experienced "procedural interruptions". Procedural interruptions included the abuser/perpetrator moving to another county or state or being deported, the woman moving, hiding, missing her court date, returning to live with the abuser, or deciding to discontinue the process, frequently because of difficulties in child visitation. In addition, several of the qualified women did not receive the protection order because the perpetrator could not be served legal papers, usually because of an incorrect address. Many women related stories of frustration such as a.) Not knowing when to go to court, b.) Not realizing their file was incomplete and additional papers were needed and c.)

Feeling overwhelmed by the filing procedures and process. Based on previous research, the justice system outcome objectives for this research are:

- A 20 percent increase in the number of PO's issued to abused women who access a specialized urban DA office and receive the Advocacy – Case Management Intervention.
- A 30 percent decrease in the number of days from PO application to receipt of the PO for women that access a specialized urban DA office and receive the Advocacy – Case Management Intervention.

Two Theories Guide This Research

The purpose of this research is to evaluate the Advocacy-Case Management intervention designed to increase victim safety and increase the efficiency of the protection order process. Walker's three-phase cycle theory of violence (1979, 1981, 2002) and Curnow's (1997) open window phase of helpseeking and reality behaviors guide the study design.

Walker's Theory of Violence and

Curnow's Open Window Phase of Helpseeking and Reality Behaviors

"Sam beat me during each pregnancy. He threw away the vitamins, tore up the prescriptions and would not let me return to the clinic. I was too scared to go to the emergency room. I thought the nurse or doctor would ask why did I stay? I thought the violence would end when Sam got a better job. When he pointed a gun at me during the last pregnancy, I called the police."

"I never considered myself an abused woman since the slapping and hitting only occurred with Ted was drunk. When Ted beat me in front of the children and threatened to kill me, I called the police and applied for a protection order".

Walker's (1979) cycle of violence describes three distinct phases: the tension-building phase, the acute violent incident, and the calm (honeymoon) period. During phase one, the tension-building phase, the abuser becomes moody, hostile, and critical of the woman. The woman usually attempts to calm the abuser by becoming nurturing, compliant, or staying out of his way. During phase two, the acute violent incident, the abuser physically and psychologically assaults the woman. The woman is severely shaken, frightened, and threatened. She focuses on survival. Shortly after the assault phase is the calm (honeymoon) phase. During this period the abuser expresses sorrow for his actions; behaves in a loving, charming, contrite manner; and promises that the violent behavior will never happen again (Saunders-Robinson, 1991). The calm stage gives the woman hope that her partner is going to change. Throughout the three phases, Walker (1979, 1981) describes characteristic behaviors of the abused woman as denial of the partner's abuse, her injuries, or the existence of alternatives. However, Walker (1979) describes a dramatic change in abused women as they progress from the end of phase two, the violent period, to phase three. During this transition, abused women realistically assess their situation, acknowledge their inability to control or stop the abuser's violence, and express a desire to stop being a victim.

Curnow (1997) tested this transition period and found a definite period of reality within the cycle of violence, between phase two and three, when denial, avoidant, and dependent behaviors are absent and helpseeking occurs. Curnow conceptualized this period as the open

window phase of helpseeking and reality behaviors. Four propositions define this open window phase. The abused woman realizes she is a victim and is not able to stop the violence; she is most likely to reach out for help; she will learn about alternatives to violence, and she is most receptive to intervention. Curnow's findings agree with other research findings that women are more likely to seek help following a violent episode (Gondolf & Fisher, 1988; McFarlane, Soeken, Reel, Parker, & Silva, 1997; Wiist & McFarlane, 1998). The contact most commonly sought is with the justice system or law enforcement (Taylor 1995; Greenfield et al., 1998; Tjaden & Thoennes, 2000). Since contact with the justice system, such as police contact or application of a civil protection order, usually occurs immediately, or within 24 to 48 hours of a violent incident, abused women seeking a civil protection order should be in transition from phase two to phase three of the Cycle of Violence and into Curnow's Open Window Phase of helpseeking and reality behaviors.

It was hypothesized that: Abused women who contact the justice system and receive an intervention to increase safety-seeking behaviors would report significantly more adopted safety behaviors, less violence and better health functioning at 3, 6, 12 and 18 months following the Advocacy Case-Management intervention than a group of abused women who receive usual care.

Components of the Advocacy - Case Management Intervention

Advocacy

Advocacy is defined as working with and on behalf of targeted individuals, assisting them in accessing needed resources (Sarason, 1976). A core condition that is frequently cited as requiring an advocacy intervention is vulnerability of a person or a group (Mallik, 1997). While advocacy programs for abused women have grown in the past 20 years, Peled & Edleson (1994)

found that the literature defining advocacy for abused women "is almost nonexistent and there is no systematic research in its parameters" (pg. 285). A survey of 379 advocacy services for abused women found that the major issues and concerns of abused women when using advocacy services were: a.) difficulties accessing needed services, b.) fear of the abuser and maintaining safety for the woman and her children, c.) legal issues such as securing a protection order, d.) emotional and interpersonal issues, and e.) issues dealing with children and parenting (Peled & Edleson, 1994). Furthermore, this same survey revealed that advocates spent most of their time working with the legal system on behalf of the victim (i.e. family and criminal court, DAs and prosecutors).

Advocacy models have often been proposed when intervening with abused women to assist them in ending the violence in their lives. These models have also indicated that when abused women work with advocates, they experience less violence over time, report higher quality of life and social support, and had less difficulty obtaining resources (Donato & Bowker, 1984; Sullivan et al., 1994; Weisz, Tolman, & Bennett, 1998). While there have been a few studies that have examined advocacy models for abused women in clinical or shelter settings, there have been no studies that evaluated advocacy offered through the criminal justice system.

Case Management

Closely associated with advocacy is case management, a process that seeks to coordinate agencies and resources to promote optimum client care (ANA, 1988; Mundt 1996). A growing number of reports discuss the apparent effectiveness of case management interventions in improving quality of care and achieving cost savings with a variety of different client groups (Ethridge & Lamb, 1989; McKenzie, Torkelson, Holt, 1989; Mahn, 1993). However, no published reports were identified that used a case management approach with abused women. It

is important to view the abused woman as a person who can make decisions and collaborate with others to solve her dilemma (Yam, 1995). Allowing the abused woman to the express her feelings to a nonjudgmental and empathetic person, and make her own decisions about the future is central to advocacy and case-management (Newman, 1996). Case management will focus on adoption of safety behaviors and utilizing support services for abused women in the community. Networking people into specific community resources is a primary component to the success of case management approach (Stempel, Carlson & Michaeis, 1996).

Expected Benefits of the Advocacy-Case Management Intervention

1. **Enhanced Victim Safety**. Research has documented that victim safety and health is significantly enhanced if a protection order is received (Gist, 2001a). However many applicants become weary during the application process and chose to "drop" the application as they deal with the respondent's responses to the protection order. By contacting the victim weekly after initial application, the advocate can ascertain the victims present concerns with the respondent and offer anticipatory guidance about his expected behavior. The advocacy phone contacts will provide an opportunity for the victim to vent her frustrations and the advocate to review expected behavioral patterns associated with Cycle of Violence and "honeymoon" stage. Additionally, the advocate will review safety-seeking actions, offer educational information, and tailor referral sources to the woman's unique situation. Under the current system, a caseworker is only able to make one follow-up phone call during the entire protective order process.
2. **Enhanced Victim Services**. The advocacy intervention will enhance service to the victim by offering 6 scheduled telephone contacts with the system - five more contacts than are offered during the current process. During each of the 6 planned advocacy phone contacts,

the victim was offered a status update on any missing pieces of information from her application. The traditional application process places total responsibility on the victim to secure and present all required information. This process has resulted in about 30% of applicants not receiving the protection order because of missing information from her file. In contrast, the advocate functioned to assist the woman toward securing required information by offering emotional support and strategies for accessing the needed information such as divorce or paternity decrees, medical records, or certified birth certificates. The advocate functioned to support, encourage, and compliment the woman's efforts toward completion of her file. An additional 15% of women do not receive the protection order because they fail to appear at court. The advocate offered exact information about what to expect at court, confronting the abuser, safety measures and use of a witness. These advocacy measures were completed to reduce the number of women that fail to receive a protection order because they do not present to court.

3. **Enhanced System Accountability**. Some 50% of the women do not receive a protection order because of an inability of the system to serve papers to the respondent. To enhance system processing, the researchers checked the filing status of each applicant in the intervention group frequently. Appropriate offices were called to ascertain if service papers have been received and how many attempts have been made to serve the respondent. For example, the researcher telephoned the police precinct for inquiry if an officer served the protection order papers to the perpetrator. It was hypothesized that by having a person who knows the system and the process of filing protection orders, daily telephone calls until the application is advanced can enhance system accountability and result in a timelier processing and receipt of protection orders.

METHODS

Research Design.

A two group experimental design with an intervention utilizing random assignment to control group (usual District Attorney procedures) or experimental group (Advocacy Case Management Intervention) and repeated measures at three, six, twelve, and 18 months was used. A randomized control trial permits direct measurement of the intervention while controlling for both intrinsic factors (variables unique to the woman, such as educational level, years of abuse, community services used) and extrinsic factors (variables external to the woman such as resource availability, community responsiveness to abuse). Randomized control trial permits direct recommendations for program and policy implications. Similar recommendations cannot be justified with descriptive program designs or quasi-experimental designs in which women are not randomized to a control or experimental group. Intimate partner violence was defined as meeting qualifying criteria for a protection order in the state where the study was completed. The criteria are presented under sample criteria.

Sample Criteria.

The sample for this study consisted of all women, 18 years or older, applying and qualifying for a protection order against a sexual intimate. At the agency where this study was completed, criteria for qualification for a protection order are set by state law and include providing evidence (i.e., police or witness report, visible injury) that the Respondent (e.g., abuser) has been violent with them and are likely to continue this violence towards them. Additionally, the applicant must have previously lived with the abuser in the same household or be the biological parents of the same child (Texas Family Code, Title 4). Women are informed at

the time of application at the district attorney's office if they qualify or not for a protection order. Only qualifying applicants were invited into the study. Other sample criteria include the woman English or Spanish speaking. One woman spoke Russian and did not meet sample criteria.

Power Analysis and Sample Size.

Based on a pilot study (Gist, et al., 2001a) where a statistically significant difference was measured for women receiving the PO, a 0.45 (medium) effect size was expected with the Advocacy Case Management Intervention group. Using a medium effect size of .45, a power of .80 and alpha of .05, 60 women were required for each group. Allowing 25% attrition over the 18-month study time, a sample of 75 women in each group is required (Lipsey, 1990).

Sample Retention Methodology.

Abused women, as a cohort, are a vulnerable, transient population to follow. In order to maintain a high retention rate for this 18-month longitudinal study, a systematized tracking methodology was incorporated, which has been shown to have an efficacy rate of 96% contact/response rate during a longitudinal study with a sample of battered women exiting shelters (Rumpz, 1991), a 94% retention rate with pregnant women (McFarlane, et al., 1998), and a 95% retention rate with abused women who contacted the criminal justice system (McFarlane, et al., 2000a). This successful methodology began with asking each study participant for several names, addresses, and phone numbers of individuals (e.g. family members, friends, neighbors, employers, community organizations) who could be could be used as alternate contacts, which will invariably have knowledge of the whereabouts of the study participant. After each contact with the study participant the investigator provides a business card containing the name of the investigator and other project staff and phone number of the research project. In addition to these successful retention strategies, we provided incremental monetary

incentives of $20 for first base-line interview, $30 for the second 3-month interview, $40 the 6-month interview, $50 for the 12 month, and $60 for the 18-month interview with a $40 bonus for each woman completing all interviews.

The base-line interview was completed in person and the woman was offer $20 cash. The four remaining interviews at 3-, 6-, 12 and 18-months were completed over the telephone. The six intervention contacts were completed over the telephone. All interviews and intervention contacts were completed by the interviewer that initially entered the woman. All interviewers remained with the study for 18-months

When all phone and written contacts with the study participant failed, project staff used the successful field community tracking strategies outlined by Block & McFarlane (1999). When tracking is completed in the community, the McFarlane and Wiist (1997) safety plan for home visits with abused women in the community was followed. The safety plan is detailed and includes a.) working in pairs as often as possible, b.) carrying a cell phone, preferably on your person; c.) making someone aware of the tracking destination and expected time of return to the office. Using these safety tracking strategies, we were able to maintain 100 retention of the sample over the 18 month study period. No threats to personal safety were experienced.

It is important to note that women in this study presented to the special division of the District Attorney's Office to apply for a protection order. Choosing to access justice services makes the intimate partner violence public. While at the justice office, each woman signed a notarized statement to the extent of the abuse and provided witness and or police report documentation. At the conclusion of each of the six telephone intervention calls and four follow-up phone interviews, the women provided a safe time and phone number to the investigator for the next contact. Many of the women requested we call them at work, during a break or lunch

period. Most women in the study had cell phones and requested the investigator call them at the cell phone number. Investigators called the woman exactly as requested. For example, if the safe time for a phone interview was 9 pm on a Saturday night, then that is when the investigator called and completed the interview. Interviewers used cell telephone or the agency phone to make the calls to women or her contacts due to caller identification on many phones. All women were sent reminder letters about the next interview with their investigator's name and phone contact on a card referring to the "Women's Health Study". Study women continually commented on how fortunate they felt to be part of a "Women's Health Study" and how important it was to them to be making a contribution towards women's health and safety.

Many women reported a change of address at each stage of follow-up. Specifically, between 3 and 6 months, 32 of the 149 women (21%) reported a new address; between 6 and 12 months, 47 of the 149 women (32%) reported a new address and between 12 and 18 months 42 of 149 (28%) of the women reported a change. Some women had a different address for each interview.

In addition to the safe contact list, tracking procedures, incremental incentives and an interview schedule focused on the woman's safety, the six investigators maintained close contact with each other and had frequent debriefing and team sharing sessions. With six investigators on the team, each investigator had an average of 25 women in their case load, an average of 12 intervention women and 12 control group women. This small case load greatly facilitated contact and completion of all study interviews. As this was a collaborative study between health and the justice system, the sponsoring agency, the District Attorney's Office, was extremely supportive of the research and helpful in day to day tasks of securing private interview space to talk with study women, use of the telephones to track protection order processing and updating the status

of the woman's order of protection. The 100% retention would have been impossible without the exemplary collaboration of the justice agency, the preparedness and dedication of the research team, and the intent of the abused women to make a contribution to the safety and welfare of other abused women.

So important are issues of successful recruitment and retention of victims and offenders in research studies that the National Institute of Justice (NIJ) has contracted a best practices report on the topic. The author of this report has written a section of the best practices report entitled "Successful sampling, recruitment and retention strategies for female victims of intimate partner violence". Within this contracted report critical issues including establishing a working partnership with the service agency, investigator presence and involvement at the service agency, nurturing agency staff and the recruitment, training, and maintaining of a qualified research team are discussed in detail. Additionally, safe field tracking protocols for longitudinal research are offered as well as the detail procedures of a safe contact list, successful use of incentives, and strategies for regaining contact with "lost" subjects. Readers are advised to contact the Office of Justice Programs for further information on the status of this paper.

Setting and Services Offered.

The Family Criminal Law Division (FCLD) of the Harris County District Attorney's Office is located in Houston, Texas, and serves an ethnically diverse population of 2.8 million citizens. The Division was created in 1984 in an effort to bring special attention and services to victims of domestic violence. Services include protective orders; crisis intervention for victims of domestic violence; intake for parental kidnapping/interference with child custody, bigamy, criminal non-support, and harboring a runaway. The Division consists of 17 full-time staff members including 1 Chief Prosecuting Attorney, 3 Prosecuting Attorneys, 1 Protective Order

Prosecutor, 2 Investigators, 6 Caseworkers (several of whom are bilingual in Spanish or Vietnamese), 4 Administrative Aides, and 2 legal interns. Caseworkers prepare a case history for each applicant of a protection order and advise the individual of their qualification status. Counseling and referral information is offered to each applicant. Over 3,000 clients are served each year. This research study began in December 2000 and ended in August 2002.

The specific process of the protection order is as follows. If the applicant's case is accepted, the attorney's file the case with the Family Law Courts, and ask for a court date to be set for a hearing. After the case is filed, the court issues a temporary protection order. A copy of this order is sent to the applicant by mail, and a copy is served to the abuser in person. The temporary protection order is similar to the final 2-year protection order, in that it tells the person to stay 200 feet away from the applicant's home and workplace, and prohibits the person from assaulting the applicant, from threatening the applicant directly or through another person, and from harassing or stalking the applicant. However, the temporary protection order differs from the final two-year protection order in that a violation of the temporary order cannot be charged as a criminal offense; it can only be filed as a civil contempt of court. Furthermore, the temporary protection order is only valid for 20 days. The court date is set within those 20 days and the order expires whether or not the abuser is served or the hearing takes place. However, the temporary protection order may be extended if the abuser is not served by the hearing date.

Protocol for Control and Intervention Groups: Control Group.

Women randomized to the control group were offered standard services of this specialized district attorney's (DA) office, which consists of individual counseling and community referral information on violence. All applicants are routinely given the name and phone number of their intake interviewer and encouraged to telephone the DA's office for further

assistance. Following routine DA procedures, control group women were offered a card and time for the 3, 6, 12 and 18-month interviews. Women were compensated for each interview.

Intervention Group

Women randomized to the intervention group were offered the standard services of the DA's office plus six advocacy case management intervention telephone calls. The focus of the advocacy case management intervention telephone calls was increasing victim safety. Each telephone call began with a review of safety-seeking behaviors, using the Safety Behavior Checklist (Exhibit A). Because violence against women is one facet of a syndrome of coercive control by the abuser, the review of safety-seeking behaviors is directed toward increasing the woman's independence and control (Gondolf & Fisher, 1988; Herman, 1992). This safety protocol is based on the McFarlane's and Parker's abuse prevention protocol (1994) that was previously tested and proven effective with pregnant women (McFarlane, Parker, Soeken, Silva, & Reel, 1998; Parker, McFarlane, Soeken, Silva, & Reel, 1999).

The first intervention call occurred within 48 to 72 hours of the initial visit. Remaining calls occurred at one, two, three, five and eight weeks following intake. The investigator that entered the woman into the study completed all follow-up telephone calls. Each call began with the safety behavior checklist, noting behaviors adopted since the last contact (Exhibit A). Strategies for adopting safety behaviors were discussed. For example, women were given information on making extra keys, obtaining copies of birth certificates or a marriage license; and applying for a driver's license. The importance of possessing documents such as rent and utility receipts, social security numbers, and birth certificates was discussed. Women were offered suggestions on where to hide money, or important documents, such as in an empty tampon container, with sanitary products, or with a trusted friend, neighbor, or relative. The

women were coached in how to develop a code to use with family and friends to signal the need for assistance as well as identify a neighbor who could be asked to call the police if an altercation was heard. If weapons were in the house, women were offered strategies for removal and disposing of them with law enforcement officials. The telephone calls ranged in duration from three minutes to twenty-five minutes, with a mean of nine minutes per call. The safety intervention ended with the sixth telephone call, eight weeks after the initial entry into the study. At the 3, 6, 12 and 18-month follow-up calls, no information on safety was provided to the intervention group women.

Following a review of safety behaviors, education on the process of protection orders, including how to request and obtain necessary documents, was provided. Additionally, as appropriate, information was offered to the woman on "usual" reactions of children to witnessing abuse (fear, sleeping disorders, aggressive or violent behavior toward others, talking about retaliating) as well as feelings of fear, loss, and despair the woman may experience. Possible perpetrator behaviors in response to the protection order were discussed with emphasis on maintaining safety. Finally, guided referrals were made as needed as well as supportive care in the form of active, empathic and non-judgmental listening was offered.

INSTRUMENTS

To measure the victim objective of increased safety-seeking behaviors, lower levels of experienced violence, higher physical and emotional functioning, and greater employment productivity among women who receive the intervention, all women were administered the following instruments at baseline and 3-, 6-, 12-, and 18 months. All instruments were administered in an interview format.

Safety Behaviors Checklist.

This 15-item safety survey is administered to assess for present use of safety behaviors and chart future adoption. At the first assessment, the woman is asked "Have you EVER ....?.". At subsequent sessions, the women are asked "Since the last time we talked, have you ....? The safety behavior checklist was initially described in Abuse during pregnancy: A protocol for prevention and intervention (McFarlane & Parker, 1994) and since has been tested and proven extremely effective on an ethnically diverse population of 199 abused Hispanic, Black, and White women attending prenatal clinics (McFarlane, Parker, & Cross 2000). See Exhibit A

To score the safety behavior checklist, an adjustment procedure was used. Because not all behaviors were applicable for each woman, the total number of behaviors was adjusted to facilitate interpretation and comparison. The total number of behaviors performed was adjusted so that each woman's total fell within the range of zero behaviors performed (0) and all behaviors performed (15). The adjusted total behaviors performed were computed by multiplying each woman's percent of applicable behaviors by 15 and dividing by 100%. For example, if a woman was single, did not have a weapon in the home, an insurance policy or a bank account and practiced all but one applicable behavior, her total score would equal 10. Her percent of applicable behaviors is 10/11 = 90.9% and adjusted total number of behaviors performed is 90.9% x 15/100% = 13.6. Assume a second woman also performed 10 behaviors, however all but one behavior was applicable. Therefore the second woman's percent of applicable behavior is 10/14=71.4% and adjusted total number of behaviors performed is 71.4 x 15/100% = 10.7. Although both women performed the same total number (10) of 10 safety behaviors, one woman performed almost all (90%) applicable behaviors whereas the second woman performed less than three-fourths (71%) of applicable behaviors. To determine if the

adjusted safety behavior scores changed over time, data were analyzed using a repeated measures analysis of variance (RM ANOVA) with one between-groups factor.

Severity of Violence Against Women Scale (SVAWS).

A 46-item questionnaire designed to measure threats of physical violence (19-items) and actual physical trauma (27-items) (Marshall 1992). For each behavior, the woman responds using a four-point scale to indicate how often the behavior occurred (never=1, once=2, few times=3, many times=4). Reliability has been recorded as .89 for the Threats dimension and 0.91 for the Violence dimension (Wiist & McFarlane, 1998). (See Exhibit B)

Stalking Victimization Survey (SVS).

The SVS is a 17-item yes/no questionnaire. Eight items were developed by Tjaden & Thoennes (1998) as part of the Violence and Threats of Violence Against Women in America Survey. Examples of items include: being followed or spied on, sent unsolicited letters or written correspondence, or finding the perpetrator standing outside the victim's home, school, or workplace. Content validity was established by a panel of experts. Ten items were added from the Sheridan (1998) HARASS instrument to form the 17-item SVS used in the present study. Examples of items added include threats by the abuser to harm the children or commit suicide if the woman left the relationship, leaving scary notes on her car, or threatening her family. (See Exhibit C)

Danger Assessment Scale (DAS). This 15-item questionnaire with a yes/no response format is designed to assist women in determining their potential risk for becoming a homicide victim (Campbell, 1986). All items refer to risk factors that have been associated with murder in situations involving abuse. Examples of risk factors include the abusers possession of a gun, use

of drugs, and violent behavior outside the home by the abuser. Initial reliability of the instrument was .71 and ranged from .60 to .86 in five subsequent studies (Campbell, 1995). (See Exhibit D)

MOS SF-12 Health Survey.

The SF-12 (Ware, 1998) is a shorter version of the SF-36 (Ware, 1993) and was used to assess health status across physical and emotional domains. The reliability (test-retest and internal consistency) and validity of this instrument has been well established in diverse populations and languages. Normative values for the U.S. by age and gender allow for comparison with the study population. (See Exhibit E)

Employment Harassment.

Eight questions were asked about worksite harassment. The questions are from a recent report to Congress (GAO/HEHS, 1998) that reviewed studies of worksite harassment of women by intimate partners. The questions are to be answered as yes or no. Additionally, one-opened ended question asks how the abuser prevented the woman from working. Internal consistency, a measure of reliability, produced a coefficient alpha of 0.76 (McFarlane, Malecha, Gist, Schultz, Willson & Fredland, 2000). (See Exhibit F)

Recruitment Procedures

All applicants that were female, qualifying for a protection order against a sexual intimate, and who spoke English or Spanish were invited into the study by one of the investigators. One investigator was present at the district attorney's office each day. Sampling with randomization to treatment or control group continued for 28 days until 75 women were entered into the control group and 75 women entered into the treatment group. A total of 154 women qualified for the study and were invited to participate. Four women refused to participate. The primary reason given for refusal to enter the study was pain from physical injuries. One

woman committed suicide six weeks into the study. All remaining 149 women completed the 3, 6,12, and 18 month follow-up interviews.

Analysis Procedures

Analyses was conducted to examine the study output goals of: a.) a 20% increase in the number of protection orders issued to abused women who access a specialized urban district attorney's office and participate in an advocacy case management intervention program; and b.) a 30% decrease in the number of days from application to receipt of protection orders for abused women who access a specialized urban district attorney's office and participate in an advocacy case management intervention program. Chi square analyses were performed on the control and experimental output data. Group differentiation in the demographic characteristics was investigated using independent t tests and chi-square tests of independence. Characteristics exhibiting significant group differences where included in subsequent analyses.

To measure the study outcome goal for the victim, specifically an increase in safety-seeking behaviors and health functioning and a reduction in reported severity of violence (threats and actual abuse), stalking, work harassment and danger of femicide, a mixed model repeated measures MANCOVA was used. The between factor was group (control or intervention) and the within factor was time (3-, 6-, 12-, 18-month follow-up interviews). Baseline scores were used as covariates. This method allows testing the main effect of group, the main effect of time, and the time by group interaction. If the global test reveals statistical significance, post-hoc comparisons were conducted.

RESEARCH RESULTS

Demographics (Refer to Exhibits G and H)

Demographics for the study sample of 150 women appear in Exhibit G. Demographics for the intervention and control groups appear in Exhibit H. The mean age (30.3) for women in the intervention group was significantly (F1,148)=8.903, p=.003), less by almost 5 years than the mean age (34.6) reported by the control group women. With the exception of age, there were no significant differences between groups for highest grade of schooling completed, self-identified racial/ethnic affiliation, relationship to the abuser or language spoken. The retention rate for the duration of the study was 100% for the intervention group and 99% for the controls. (The woman who committed suicide was in the control group).

Victim Safety, Violence and Health Results (Refer to Exhibits I, J, and K)

The victim outcome objective for this study is:

- More safety-seeking behaviors, lower experienced violence, higher physical and emotional functioning, and less employment harassment among women that receive the Advocacy-Case Management intervention as compared to women that do not receive the intervention.

To determine if the adjusted safety behavior scores, danger scores, stalking scores, and work harassment scores changed over time, data were analyzed using a repeated measures analyses of (co)variance (RM AN(C)OVA) with one between-groups factor. Doubly multivariate analyses of (co)variances (D MAN(C)OVAs were performed using the SVAWAS (threats and actual violence) scores and the SF-12 (physical and mental health) scores. Appropriate follow-up procedures were performed when necessary. To control for inflated type I error due to multiple testing, Bonferroni's method of adjustment was used to adjust the significance level to .01 for each comparison to maintain the experiment wise error rate of .05 (.01 x 5 administrations =.05).

Means and standard deviations for the adjusted total number of safety behaviors performed, SAVAWS scores, stalking, danger, and work harassment scores, and SF-12 health scores administered to the intervention and control group women at intake, 3-, 6-, 12-, and 18-months are shown in Exhibit I.

Victim Safety Results (Refer to Exhibits I, J and K)

Results from a RM ANOVA on safety behaviors showed a significant ($F(4,144)=5.450$, $p<.001$) main effect over time, a significant group by time interaction ($F(4,144)=2.8111, p=.028$), and a significant ($F(1,147)=23.724, p<.001$) main effect for group. Because of the significant group by time interaction, follow up tests included t tests of the simple effects at each time period (intake, 3-, 6-, 12-, and 18- months) as well as RM ANOVAs for each group (intervention and control) separately over time. Tests of simple effects showed that there were significant differences between the intervention and control group scores for 3-mos ($p < .001$), 6-mos ($p < .001$), 12-mos ($p=.002$), and 18-mos ($p=.002$). Results from the RM ANOVA for the intervention group showed that all of the follow-up scores were significantly different ($p < .001$) than the intake score. The control group scores were not significantly different ($p < .01$). These results indicate that the intervention group practiced significantly more safety behaviors than the control group women at 3-, 6-, 12-, and 18- months. Women in the intervention group also practiced significantly more safety behaviors after intake.

Using a RM ANOVA, a trend analysis was performed to model the increase in the number of applicable safety behaviors adopted by women at each intervention telephone call over time. Results indicated a significant main effect for time ($F(6,444)=91.24$, $p < .001$), and particularly a significant ($F(1,74)=69.48$, $p < .001$) quadratic trend. As shown by Exhibit J, with the quadratic trend, the number of adopted safety behaviors increase sharply for the first 4 phone

calls and then increases slightly for the remaining calls. Means and standard deviations are also reported in Exhibit K and initially, 10.4 (69%) of the applicable safety behaviors were performed at intake but by week eight of the intervention, 13.9 (92%) of the behaviors were adopted.

Victim Violence Results (Refer to Exhibit I)

Results from the D MANOVA of the SAVAWS yielded a significant ($F(8,1176)=70.188$, $p<.001$) multivariate main effect for time (main effect for time considering the mean of all the women at each time period). Univariate tests showed a significant main effect for time for Threats ($F(4,588)=78.988, p<.001$) and Actual violence ($F(4,588)=62.876$, $p<.001$). Follow-up RM ANOVAs for the main effect for time showed significant differences (.001) between each time period (3 to 18 months) when compared to intake for threats of violence and actual violence. The intake scores for threats and actual violence were significantly higher at intake than scores assessed during the subsequent months. Although there were no group differences, results from the RM ANOVA showed significant ($F(4,144)=82.133$, $p<.001$; $F(4,144)=124.535$, $p<.001$; $F(4,81)=50.805$, $p < .001$) effects over time for stalking, danger, and work harassment scores. Follow-up tests for the main effect of time showed that the scores at intake was significantly ($p < .01$) higher than the subsequent scores. Although analyses of covariance and multivariate analyses of covariance were performed adjusting for age, the results were not changed and therefore the results are not presented.

Victim Health Results (Refer to Exhibit I)

Results of the D MANOVA yielded a significant ($F(8,1176)=30.928$, $p<.001$) multivariate main effect for time. Univariate tests showed the main effect for time was significant for Physical Health ($F(4,588)=3.719$, $p<.001$) and Mental Health, ($F(4,588)=71.011, p<.001$). Follow-up RM ANOVAS showed that the mental health intake score

was significantly ($p < .01$) worse than the subsequent assessments. However, the physical health intake score was significantly ($p < .01$) worse than the 3 months and 12 months assessment only. Although analyses of covariance and multivariate analyses of covariance were performed adjusting for age, the results were not changed and therefore the results are not presented.

Justice System Results (Refer to Exhibits L and M)

Two justice system outcomes were proposed as follows:

- A 20 percent increase in the number of protection orders issued to abused women that access a specialized urban district attorney office and receive the Advocacy – Case Management Intervention.
- A 30 percent decrease in the number of days from protection order application to receipt of the protection order for women that access a specialized urban district attorney office and receive the Advocacy – Case Management Intervention.

Exhibit L presents the number of women receiving a protection order according to intervention or control group membership. Using chi square analysis no significant difference were found in protection order receipt between the treatment and control groups. Some 56% of the intervention women (n=42) received a protection order compared to 52% (n=39) of the women in the control group. This difference of three women was not significantly higher (Π^2 (1)=0.242, p=.623) and not 20% higher. The reasons the women did not receive a protection order were not significantly different (Π^2 (1)=0.242, p=.623) between the intervention and control groups. Exactly the same number of women in both groups did not receive a PO due to the inability of the system to serve the perpetrator. Although not statistically different, none of

the women in the intervention group failed to show in court; whereas three women in the control group did not receive the PO due to failure to show in court.

Exhibit M presents the number of days from application to receipt of the protection order for intervention compared to control women. Again, using chi square analysis no significant differences were found in number of processing days between the treatment and control groups. The mean number of days for receipt was 24 days for both groups of women. Similarly, there were no significant differences between the numbers of days required for any step in the protection order process.

CONCLUSIONS & IMPLICATIONS

Increasing Victim Safety

Adoption of safety behaviors significantly increased over time for women in the intervention group. The effect of the intervention was large at 3 months (ES=1.5), remained substantial at 6 months (ES=0.56), and then stabilized and remain consistent at 12 and 18 months. The decrease in effect size measured at six months may indicate the need for an additional intervention session(s) or the data may indicate a ceiling effect of the intervention.

The significant increase for intervention women in adopting additional safety-seeking behaviors from one telephone session to the next is impressive. Within the first 7 days of the intervention period, the mean number of safety behaviors performed increased by more than two, 10.4 to 12.6, with an increase of applicable behaviors performed from 69% to 84%. Many of the safety behaviors require great effort and major risk taking. For example, the seemingly simple act of making an extra key requires the steps of obtaining the key (many abusers keep house and car keys on a ring attached to a belt worn at all times), locating and securing transportation to a key duplication site (for several women this meant identifying a trusted person from which to

request transportation or learning and completing lengthy bus transfers from their homes), and returning the key to its original location without the abuser's knowledge (women reported securing and copying the key while the abuser slept). Despite these difficulties, the women were eager to share stories of their success, for example, telling a neighbor about the abuse and asking the person to phone the police if they lower their kitchen window shade (which normally remained up). Women devised creative codes to use with family and friends to alert them to potential violence (i.e., transposed birth date, asking about a deceased relative, requesting a food item to which they had an allergy). Removing weapons and hiding a bag with extra clothing can be dangerous. However, more than 70% of the intervention women reported adopted these safety behaviors.

Concerning are the safety behaviors that some intervention women reported adopting at three months but no longer practiced at six months, such as hiding keys and a bag with extra clothing as well as establishing a code with others and asking neighbors to call the police. As the time interval increased since the violent episode for which the woman sought help, some women reported, "feeling safer" and did not feel the need to practice all the safety behaviors. Many women reported moving to a new residence and wanting to "forget the past", deciding not to inform new neighbors about past violence or ask for assistance should an altercation be heard.

These statements of perceived safety, although anecdotal, are especially alarming if the woman considers the abuser a former partner. Research documents divorced or separated women but report up to four times more intimate partner violence than do married women (Dobash & Dobash, 1984; Stark & Flitcraft, 1988; Ellis & DeKeseredy, 1989). Also, interviews with men who have killed their wives indicate that either threats of separation by their partner or completed separation are most often the precipitating events that lead to the murder (Bernard &

Bernard, 1983; Daly & Wilson, 1988). Clearly, a decrease in practiced safety behaviors at six months indicates a closing of Curnow's open window phase and supports the need for an additional intervention(s) to maintain safety-seeking behaviors. Women must be advised of the increased potential for violence following a separation from the abuser and the continued need for safety behaviors.

These results indicate the longer the time interval after the abusive incident; the less likely women are to adopt safety behaviors. How long is the open window phase open? The length of time after the violent episode this intervention can be applied with expected results is unknown. Correlates such as relationship status (current versus former), type, frequency, and severity of violence, and previous help seeking actions must also be considered in future replication research. To our knowledge, this research is the first randomized clinical trial of a safety intervention for abused women. These findings clearly demonstrate that an intervention to increase safety behaviors of abused women is highly effective when offered following an abusive incident. The effectiveness of the safety intervention remains substantial at six months. The average length of time required to apply the intervention was only 54 minutes (e.g., six nine-minute phone calls), less than one hour of professional time. The low intensity of this intervention makes it feasible to be integrated into a variety of agencies in both urban and rural settings. Additionally, the cost of the intervention is minimal and the averted trauma and associated suffering and costs potentially large.

All women, irrespective of intervention or control group, reported lower levels of intimate partner violence and higher health functioning status or up to 18 months after applying for a civil protection order. This study followed women after application for a civil protection order, irrespective of receipt or dropping of the order. Therefore, this study's design prevents a

comparison with other studies about PO because all other researchers have only reported on women who received the order of protection against the abuser (Kaci, 1994; Keilitz, Hannaford, & Efkeman, 1997; Ptacek, 1999).

The reduction in violence scores over time for all women, regardless of receipt or dropping of the protection order application, is consistent with abuse-intervention findings by social and health researchers. When abused women exiting a shelter and receiving home social support were compared at 6-months to abused women not receiving the support, women in both groups reported a decrease in physical abuse (Sullivan, Campbell, Angelique, Eby & Davidson, 1994). In health clinic studies of abused women receiving intensive counseling and outreach support compared to abused women offered a wallet-sized card that listed community resources that dealt with abuse, women in both groups reported significantly lower levels of abuse at 6- and 12- and 18-months post intervention (McFarlane, Soeken, & Wiist, 2000; Parker, McFarlane, Soeken, Silva, & Reel, 1999).

The findings that all the women in this study, regardless of receipt or dropping of the protection order, reported significantly less violence at follow-up may be due but simply to the fact that the women chose to initiate action with the justice system. This finding seems to emphasize the importance of justice system contact with abused women. A decision to contact the justice system may indicate to the abuser that official agencies know about the abuse and may act to deter any future violence against the woman, especially if the perpetrator fears jail or losing prestige in a community.

Increasing Protection Order Receipt & Process Efficiency

Slightly more than half of the women in this study (54%) completed the process of applying for and receiving a protection order. This finding is higher than previous studies with

reported protection order receipt rates of 28.8% (Fernandez, Iwamoto & Muscat, 1997), 35.5% (Gist et al., 2001a), and 37% (Zoellner et al., 2000). However, the intervention group that received the advocacy case-management and assistance with their protection order processing, received no more protection orders and in no shorter time than the control that received standard processing. Revealing is the fact that 12% of women in both the intervention and control group did not receive the protection order because the perpetrator could not be served. The inability to serve the perpetrator lies beyond the scope of the intervention tested in this study. However, the major reason that both intervention and control women did not receive the protection order was the woman choosing to drop the order of protection.

More than one-fourth of the women (28%) decided not to complete the process and dropped the protection order against the intimate partner. This drop rate was lower than the only other reported drop rate of 60% (Zoellner et al., 2000). The drop rate was the exact same percentage for both control and intervention women. When the demographic characteristics of these two groups (women that received the protection order and women that dropped the protection order) were compared, the only significant differences found were related to relationship status (current/former partner) and cohabitation status (living together at 3 months). Women who dropped the protection order were more likely to be in current relationships and living with their abusers three months after application for the protection order. Receiving a protection order was not connected to age, ethnicity, or the economic factors of education, employment, income, immigration or English speaking status. These results are supported by previous research indicating that economics, including education, and ethnicity are not significant factors in determining final protection order outcome (Fernandez et al., 1997; Zoellner et al., 2000).

When asked why they dropped the protection order, many of the women (40.5%) stated they had returned to the relationship with the abusive partner. Leaving an abusive partner and then returning to the abusive partner has been discussed at length in the literature (Baker, 1997; Campbell, Rose, Kub, & Nedd, 1998; Dutton & Painter, 1993; Griffing et al., 2002; Herbert, Silver, & Ellard, 1991; Horton & Johnson, 1993; Landenburger, 1989; Schutte, Malouff, & Doyle, 2001; Strube, 1988; Strube & Barbour, 1983, 1984). Women in this study chose to leave their abusive partners when they applied for the protection order and signed an affidavit that domestic violence had occurred and there was high risk for further intimate partner violence. When a woman then chooses to drop the protection order, the district attorney's office requests that she return to the office and sign a release form that she no longer wants to continue the protection order process. Of the 42 women in this study who dropped the protection order, 74.4% were in current relationships (intimate partner) with their abusers and 38.1% were living with their abusers.

Zoellner and associates (2000) found women who indicated an "attachment" to the abusive partner were less likely to complete the protection order process. Attachment was measured with two yes/no questions: "Do you still love your partner?" and "Do you want him back if he would change?" Women who perceived threats to themselves were more likely to complete the process however; women whose abusive partners made threats to her children were more likely to drop the process. These results continue to support other studies of women who make attempts to end the violence in their lives, but for some reason, do not continue with the process and/or return to the abusive partner (Griffing et al., 2002).

Almost one-quarter of the women (23.8%) who dropped the protection order cited that the process of obtaining the protection order was "too much of a hassle," and inconvenient. In

order to obtain a protection order, the applicants in this study had to be willing to participate in the following process: (a) arrive at district attorney's office with proper photo identification; (b) complete paperwork, interview with caseworker, take photographs, and sign affidavit (this step takes approximately 2 to 3 hours); (c) may need to return to district attorney's office at a later date with additional required paperwork and/or witnesses to the violence; (d) wait approximately 6 weeks for court date; and (e) appear in court in front of a judge where abuser may contest the protection order. During this process, the woman is told to stay away from her abusive partner. Fernandez and colleagues (1997) outlined seven similar stages to the protection order process and the possible factors that may determine whether or not an abused woman completes the process. Issues that may arise and prevent the receipt of a protection order may include transportation issues to and from the government agencies, taking time away from work, family, and other duties, child care issues, financial issues, fear or threats of retaliation from the abuser, and emotional commitment to the abuser (Chaudhuri & Daly, 1992; Kaci, 1992; Zoellner et al., 2000).

We found significant differences in relationship status existed at intake between the women that subsequently received or dropped the protection order. Significantly ($p<.05$) more women who dropped the protection order were in current relationships, whereas protection order recipients considered the perpetrator a former partner. Furthermore, at intake and 3 months later, women in current relationships, irrespective of subsequent protection order receipt or drop, reported significantly ($p<.005$) more physical assaults compared to women in former relationships. Clearly, relationship status is a significant correlate of abused women's receipt or dropping of a protection as well as her level of assault experienced. Relationship status must be

assessed by service providers and the implications for protection order receipt discussed with women.

Study Limitations

There are limitations of the study that are important to the generalizability of the findings. The sample used in the study was from an urban agency of women who were actively seeking assistance from the justice system. Furthermore, the study relied on self-reports that may under report or over report due to lack of recall or lack of voluntary disclosure. Research subject may respond to questions to please investigators. Therefore, intervention women may have responded favorably to safety behaviors not actually adopted. However, because the women were randomized to intervention and control groups, this potential response bias was randomly dispersed across both groups. Future research is needed with a larger community sample of abused persons, both male and female, who have been victimized but choose not to file for a protection order. Additionally, further longitudinal studies are needed to investigate the factors associated with persistence in obtaining protection orders and the barriers and decision making processes people go through in securing protection orders. Replication studies will help to further understand the reasons behind dropping protection orders after application is made. Factors need to be identified that establish if a protection order is an effective intervention for abused women, as well as a better understanding of attachment to an abusive partner and other factors that may interfere with a woman's desire to end violence in her life. More studies are needed to explore a possible theory of emotional attachment to the perpetrator. Evaluation studies of the long-term outcomes of protection orders are also crucially needed.

Summary

Clearly, the process of obtaining a protection order is not a simple and easy process. Although we applied a systematic intervention toward increasing the number of protection orders received and the decreasing the number of days from application to receipt of the order, the intervention made no difference on either desired outcome. Would improving the process, in terms of less work and hassle on the applicant's part, help abused women obtain a higher rate of protection orders? How can we better serve those women who want the protection orders but the perpetrators can not be found for service? Relationship status is significantly linked to receipt or dropping of a protection order, as well as degree of assault experienced immediately before and 3 months after application. These findings indicate the importance of assessing relationship status and the implications of relationship status when applying for protection orders. Obtaining more data on the factors associated with obtaining or dropping a protection order is a logical step.

Although the advocacy-case management intervention did not increase the number of protection orders received or decrease the number of days required to receive the order, the number of safety behaviors practiced by intervention women increased quickly and dramatically following a simple straightforward intervention that required less than one hour of time. The safety behaviors adopted may well prevent trauma and possible death. If applied following an abusive incident, this intervention is extremely effective and should seemingly be considered for immediate application at a variety of agencies serving abused women including justice, law enforcement, and social and health service providers.

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Investigators Biosketch

Dr. Judith McFarlane is the Parry Chair in Health Promotion and Disease Prevention at Texas Woman's University, College of Nursing, in Houston, Texas. Dr. McFarlane conducts research on the health effects of violence against women and the effectiveness of interventions to prevent further violence. Her research has been funded by the Centers for Disease Control, National Center for Injury Prevention, Agency for Health Research & Quality, The National Institutes of Justice, and the National Institutes of Health. Dr. McFarlane began studying intimate partner violence during pregnancy in 1984 and has since authored seminal studies on abuse of pregnant women and its connection with low birthweight. Her research findings have been presented to congressional committees, included in national health objectives, and used by clinicians in the U.S. and abroad to set standards of care for pregnant women. To improve access to early prenatal care for high-risk Hispanic women, the W.K. Kellogg Foundation funded Dr. McFarlane to design and test the program De Madres a Madres, a health care delivery model featured in TIME Magazine and excerpted on NBC "TODAY" show. Dr. McFarlane is the author or coauthor of six clinical textbooks and more than 125 peer reviewed journal articles on women's health. Dr. McFarlane presents regularly to national and international audiences.

Dr. Ann Malecha is an Assistant Professor at Texas Woman's University, College of Nursing in Houston, Texas. Her research program focuses on improving the health and safety outcomes of abused women. Utilizing her experience as an adult nurse practitioner and nurse researcher, Dr. Malecha is studying the practice and policy implications of universal screening for domestic violence in health care settings. Selected as a Chancellor's Research Fellow for 2002-2003 at Texas Woman's University, Dr. Malecha is studying the outcomes of domestic violence screening in the occupational health setting. Dr. Malecha is the author or coauthor of more than 25 publications that focus on improving the health of abused women.

Ms Elizabeth C. Batten completed her undergraduate degree at Bryn Mawr College and studied in the cultural anthropology graduate program at the University of the Americas in Puebla, Mexico. Ms Batten has worked for five years as a bilingual case worker at the Harris County District Attorney's Office in Houston, Texas. Ms Batten interviews persons applying for a protective order, and starts the protection order application process. She also interviews victims in criminal cases, and testifies in court. For the past three years, Ms Batten has participated in a cooperative research project with Texas Woman's University and the District Attorney's Office and functions as a bi-lingual investigator.

Ms Iva Hall has worked as a registered nurse since 1974 in a variety of community and hospital settings. Since 1985, Ms Hall has been on the faculty of Lamar University and functions as the coordinator of undergraduate programs. In 1998, Ms Hall began her doctoral studies at Texas Woman's University and is presently completing her dissertation on disclosure of intimate partner violence at the worksite and associated worksite assistance. Ms Hall has been a researcher/interviewer with studies related to intimate partner violence since 1998 and is the author or co-author of six peer reviewed journal articles on violence against women.

Ms Sheila Smith has been a registered nurse since 1972 and functions in a variety of professional nursing settings including in-patient and ambulatory. Ms Smith is a PhD candidate at Texas Woman's University in Houston and has been a researcher/interviewer with studies related to intimate partner violence since 1998.

Exhibits

A. Safety Behavior Checklist

B. Severity of Violence Against Women Scale

C. Stalking Survey

D. Danger Assessment Scale

E. SF-12

F. Employment Harassment

G. Demographic Data of 150 Women who qualified for a Protection Order

H. Demographics and test statistics between intervention and control groups

I. Safety Behaviors, Violence and Health Scores for intervention and control groups at Intake, 3-, 6-, 12-, and 18-Months for Intervention (n=75) and Control (n= 75) Group Women

J. Adjusted number of safety behaviors performed by time of intervention phone call for 75 women

K. Total Number of Safety Behaviors Followed and Percentage of Women Responding "YES" to Safety Behaviors at Each Intervention Phone Call for the Intervention Group

L. Receipt of protection order status fro 75 intervention women compared to 75 control group women.

M. Number of days from application to receipt of a protection order

Exhibit A

Safety Behavior Checklist
Ask the woman to answer YES, NO, or NOT APPLICABLE

Since I talked to you on _____(date of last interview), HAVE YOU:	**Yes (1)**	**No (0)**	**NA (66)**	
Hid money?				01
Hid extra set of house and car keys?				02
Established code with family or friends?				03
Asked neighbors to call police if violence begins				04
Removed weapons				05
Had available:				
Social Security Number (yours, his, children)?				06
Rent and utility receipts?				07
Birth certificates (yours and children)?				08
ID or Driver's license (yours and children)?				09
Bank account numbers?				10
Insurance policies and numbers?				11
Marriage license?				12
Valuable jewelry?				13
Important phone numbers?				14
Hidden bag with extra clothing?				15

***After the first visit, change the leading question to:**
"Since the last time we talked, have you ...?

Exhibit B. Severity of Violence Against Women Scale

Since I talked to you, which of the following behaviors has this person done and how often?

1	2	3	4
NEVER	*ONCE*	*A FEW TIMES* (2-3 times)	*MANY TIMES* (4 or more times)

1. Hit or kicked a wall, door or furniture _____
2. Threw, smashed or broke an object _____
3. Drove dangerously with you in the car _____
4. Threw an object at you _____
5. Shook a finger at you _____
6. Made threatening gestures at you _____
7. Shook a fist at you _____
8. Acted like a bully towards you _____
9. Destroyed something belonging to you _____
10. Threatened to harm or damage things you care about _____
11. Threatened to destroy property _____
12. Threatened to hurt someone you care about _____
13. Threatened to hurt you _____
14. Threatened to kill themselves _____
15. Threatened to kill you _____
16. Threatened you with a weapon _____
17. Threatened you with a club-like object _____
18. Acted like they wanted to kill you _____
19. Threatened you with a knife or gun _____
20. Held you down, pinning you in place _____
21. Pushed or shoved you _____
22. Grabbed you suddenly or forcefully _____
23. Scratched you _____
24. Pulled you _____
25. Shook or roughly handled you _____
26. Twisted your arm _____
27. Spanked you _____
28. Bit you _____
29. Slapped you with the palm of their hand _____
30. Slapped you with the back of their hand _____
31. Slapped you around the face and head _____
32. Hit you with an object _____
33. Punched you _____
34. Kicked you _____
35. Stomped on you _____
36. Choked you _____
37. Burned you with something _____
38. Used a club-like object on you _____
39. Beat you up _____
40. Used a knife or gun on you _____
41. Demanded sex whether you wanted to or not _____
42. Made you have oral sex against your will _____
43. Made you have sexual intercourse against your will _____
44. Physically forced you to have sex _____
45. Made you have anal sex against you will _____
46. Used an object on you in a sexual way _____

EXHIBIT C. Stalking Survey

Since I talked you on _____ (Date of Last Interview), has this person done the following:

Each answer is a YES or NO:	**YES (1)**	**NO (0)**	
Followed or spied on you?			01
Sent you unsolicited letters or written correspondence?			02
Made unsolicited phone calls to you?			03
Stood outside your home, school or workplace?			04
Sat in car outside your home, school or workplace?			05
Showed up at places were you were even though they had no business there?			06
Left unwanted items for you to find?			07
Tried to communicate with you in other ways against your will?			08
Vandalized your property or destroyed something you loved?			09
Killed your pet?			10
Threatened to harm the kids if you left?			11
Threatened to kill themself if you left?			12
Destroyed your property, including car parts?			13
Called you on the phone and hung up?			14
Threatened your family?			15
Left notes on your car?			16
Showed up without warning?			17

IF YES to any of the above questions, ask:

18. **As a result of these stalking behaviors, would you say you were/are: (circle answer)**

(1) Very frightened (2) Somewhat frightened (3) Little frightened (4) Not frightened **(circle if NA)**

Exhibit D. Danger Scale

Since I talked you on _____ (date of last interview):

Each answer is a YES or NO:	*Yes (1)*	No (0)	
1. Has the physical violence increased in frequency?			
2. Has the physical violence increased in severity and/or has a weapon or threat with weapon been used?			
3. Has the person tried to choke you?			
4. Is there a gun in the home where you live?			
5. Has this person forced you into sex when you did not wish to do so?			
6. Has this person used drugs? 7. By drugs I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs, marijuana, heroin, or mixtures.**(CIRCLE DRUGS USED)**			
8. Has this person threatened to kill you.			
9. Has this person been drunk every day or almost every day? (In terms of quantity of alcohol)			
10.Does this person control most or all of your daily activities? For instance, does the person tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car?			
11. If pregnant, did this person beat you? (If not pregnant in past 3 months, circle **NA**)			**na(66)**
12. Has this person been violently and constantly jealous of you? (For instance, does this person say, "If I can't have you, no one can.")			
13. Have you threatened or tried to commit suicide?			
14. Has this person threatened or tried to commit suicide?			
15. Has this person been violent outside of the home?			
16. Does this person have a rifle, shotgun, handgun, pistol or other type of firearm? **If yes**, please circle the type and note the number: rifle __, shotgun ___, handgun ___			
17. Has this person threatened to harm the children if you leave or do not return?			

Exhibit E. SF-12

1. In general, would you say your health is: (circle one answer)
   Excellent (1) **Very Good (2)** **Good (3)** **Fair (4)** **Poor (5)**

Does your health **NOW** limit you in the following activities? (check answers)

	Yes, (1) limited a lot	**Yes, (2) Limited a little)**	**No, not (3) limited at all**
2. Moderate activities, such as moving a table,pushing a vacuum cleaner, playing sports.			
3. Climbing several flights of stairs			

During the past 3 months, have you had any of the following problems with your work or daily activities as a result of your **PHYSICAL** health? (circle answer)

4. **Accomplished less** than you would like	YES (1)	NO (2)
5. Were limited in the kind of work or other activities	YES (1)	NO (2)

During the past 3 months, have you had any of the following problems with your work or other daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

6. **Accomplished less** than you would like	YES (1)	NO (2)
7. Didn't do work or other activities as **carefully** as usual	YES (1)	NO (2)

8. **During the past 3 months**, how much did pain interfere with your normal work (include both work outside the home and housework)? (circle only one answer)
Not at all (1) **A little bit (2)** **Moderately (3)** **Quite a bit (4)** **Extremely (5)**

For the past 3 months: (check answer)

	All of the time (1)	**Most of the time (2)**	**A good bit of the time (3)**	**Some of the time (4)**	**A little of the time (5)**	**None of the time (6)**
9. Have you felt calm and peaceful?						
10. Did you have a lot of energy?						
11. Have you felt downhearted and blue?						

12. For the past 3 months, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? (circle one answer)

Exhibit F. Employment Harassment

1. Have you worked/been employed during the last 3 months?	**YES (1) NO (0)**
<u>If YES</u> to working	
2. Has your partner harassed you at work in person?	**YES (1) NO (0) NA(66)**
3. Has your partner harassed you at work over the phone?	**YES (1) NO (0) NA(66)**
4. Have you been late for work or left early because of any abuse?	**YES (1) NO (0) NA(66)**
5. Have you missed work because of any abuse?	**YES (1) NO (0) NA(66)**
6. Have you been reprimanded at work for behaviors related to any abuse (IPV)?	**YES (1) NO (0) NA(66)**
7. Have you lost a job because of abuse (IPV)?	**YES (1) NO (0) NA(66)**
8. Has your partner discouraged you from working?	**YES (1) NO (0) NA(66)**
9. Has your partner prevented you from working?	**YES (1) NO (0) NA(66)**
IF YES to #9 (prevent from working), give some examples:	**NA(66)**

Exhibit G
Demographic Data of 150 Women Who Qualified for a Protection Order Against an Intimate Partner (N=150)

Characteristic	Mean (SD)
Age in Years	32.4 (2.08)
Years of Education	11.77 (9.18)

	Percent (n)
Ethnicity	
Latino/Hispanic	40.7 (61)
African American	32.7 (49)
White	26.7 (40)
Household Income	
< $5,000	16.7 (25)
$5,000 to $9,999	12.7 (19)
$10,000 to $19,999	28.0 (42)
$20,000 to $29,999	24.0 (36)
>$30,000	18.0 (27)
Employment Status	
Employed	78.7 (118)
Not employed	21.3 (32)
Relationship to Abuser	
Current partner	62.0 (93)
Former partner	38.0 (57)
English Speaking	
Yes	84.0 (126)
No	16.0 (24)
Immigration Status	
Born in US	72.0 (108)
Not born in US	28.0 (42)

Exhibit H

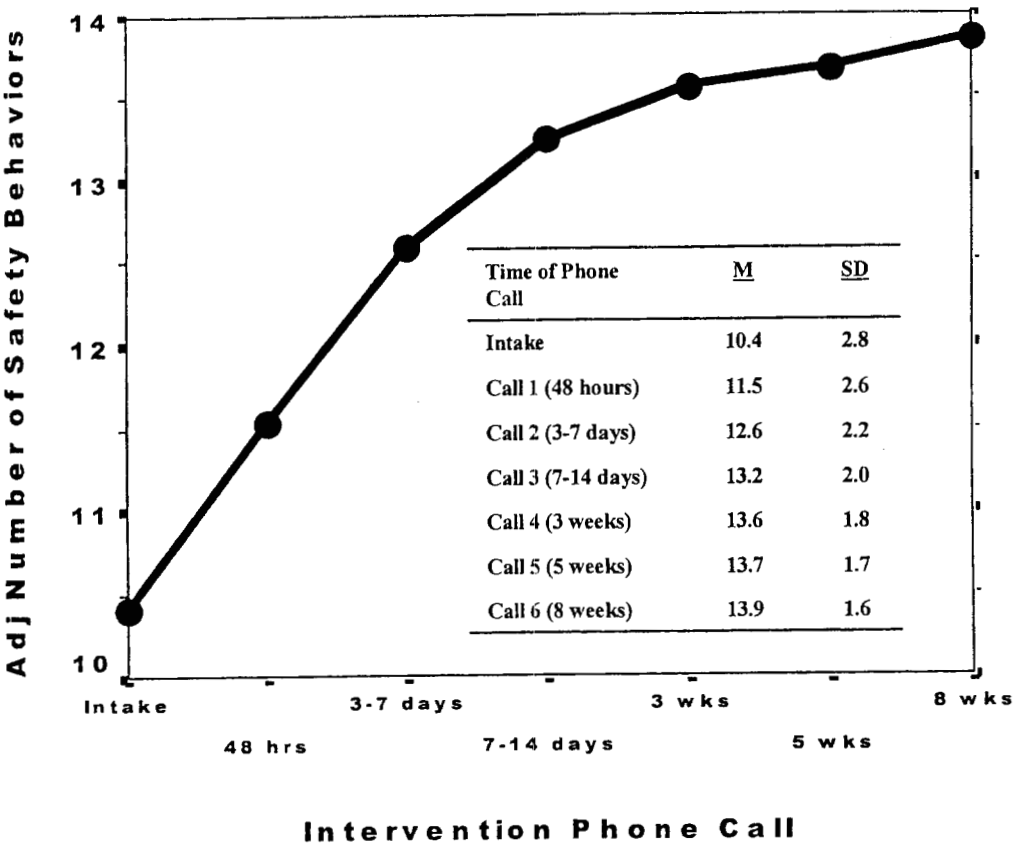
Demographics and test statistics between Intervention and Control Groups

Variable	Intervention (*N*=75)		Control (*N*=75)		Statistic
	M	(*SD*)	M	(*SD*)	
Age	30.25	7.87	34.61	9.91	t (141)=-2.98, p=.003
Grade	11.35	2.99	12.20	2.55	t (148)=-1.88, p=.062
	N	%	N	%	
Race					
African American	23	30.7	26	34.7	X^2 (2)=0.694,p=.707
White	19	25.3	21	28.0	
Latin	23	44.0	28	37.3	
Relationship					
Spouse/Common-Law	40	53.3	41	54.7	X^2 (3)=0.706,p=.872
Ex-Spouse/Ex-Common-Law	14	18.7	11	14.7	
Boyfriend/Girlfriend	5	6.7	7	9.3	
Ex-Boyfriend/Ex-Girlfriend	16	21.3	16	21.3	
Language					
English speaking	62	82.7	64	85.3	X^2 (1)=0.198,p=.656
Non-English speaking	13	17.3	11	14.7	

Exhibit I. Safety Violence, and Health Scores at Intake, 3-, 6-, 12-, and 18-Months for Intervention (n=75) and Control (n= 75) Group Women

Group Measure	Initial	3-MOS	6-MOS	12-MOS	18-MOS
	M(SD)	M(SD)	M(SD)	M(SD)	M(SD)
Intervention Group					
Safety Behaviors	10.4 (2.8)	12.5 (2.9)	12.0 (2.5)	11.9 (2.7)	12.0 (2.7)
SAVAWS:					
Threats	44.5 (14.2)	22.4 (8.5)	21.1 (6.1)	23.3 (9)	22.1 (6.7)
Actual	49.1 (18.9)	28.7 (6.2)	27.2 (1.2)	29.2 (8.5)	28.5 (5.7)
Stalking	6.9 (4.1)	2.1 (3.3)	1.3 (2.7)	1.9 (2.9)	2.0 (3.1)
Danger	6.8 (3.2)	1.9 (2.3)	1.3 (1.7)	1.6 (2.4)	1.5 (2)
Work Harassment	3.9 (1.8)	1.8 (1)	1.2 (0.4)	1.5 (0.9)	1.3 (0.7)
SF-12:					
Physical Health	48.5 (12)	49.9 (10.4)	51.5 (9.6)	51.5 (9.3)	50.2 (10.6)
Mental Health	29.2 (12.1)	39.5 (12)	43.8 (11.7)	44.8 (12.6)	46.1 (11.6)
Control Group					
Safety Behaviors	9.6 (3.1)	9.9 (2.8)	10.4 (2.2)	10.6 (2.5)	10.5 (2.6)
SAVAWS:					
Threats	47.5 (13.1)	22.1 (7.5)	22.2 (8.5)	22.7 (8.6)	22.5 (9.2)
Actual	48.6 (16.3)	28.1 (4.7)	28.8 (6.2)	28.7 (6.7)	29.0 (9.0)
Stalking	7.8 (3.8)	3.1 (3.5)	2.0 (3.0)	2.3 (3.1)	1.8 (2.8)
Danger	7.3 (2.6)	1.7 (2.2)	1.5 (2.2)	1.5 (1.9)	1.4 (2.3)
Work Harassment	4.1 (1.9)	2.4 (1.7)	1.5 (1.4)	1.5 (1.1)	1.3 (0.8)
SF-12:					
Physical Health	47.0 (12.9)	50.8 (10.2)	48.5 (11.1)	50.4 (10.2)	49.1 (10.8)
Mental Health	28.8 (10.6)	40.4 (13.9	42.9 (13.7)	44.1 (13.4)	44.3 (12.9)

*n=74 for control group



Time of Phone Call	M	SD
Intake	10.4	2.8
Call 1 (48 hours)	11.5	2.6
Call 2 (3-7 days)	12.6	2.2
Call 3 (7-14 days)	13.2	2.0
Call 4 (3 weeks)	13.6	1.8
Call 5 (5 weeks)	13.7	1.7
Call 6 (8 weeks)	13.9	1.6

Exhibit J. Adjusted number of safety behaviors performed by time of intervention phone call for 75 women.

Exhibit K. Total Number of Safety Behaviors Followed and Percentage of Women Responding "YES" to Safety Behaviors at Each Intervention Phone Call for the Intervention Group

	M	*SD*
Intake		
No. of Behaviors Performed (Adjusted)	10.4	2.8
% of (Applicable) Behaviors Performed	69.4	18.7
Call 1 (48 hours)		
No. of Behaviors Performed (Adjusted)	11.5	2.6
% of (Applicable) Behaviors Performed	76.9	17.3
Call 2 (3-7 days)		
No. of Behaviors Performed (Adjusted)	12.6	2.2
% of (Applicable) Behaviors Performed	83.9	14.9
Call 3 (7-14 days)		
No. of Behaviors Performed (Adjusted)	13.2	2.0
% of (Applicable) Behaviors Performed	88.3	13.4
Call 4 (3 weeks)		
No. of Behaviors Performed (Adjusted)	13.6	1.8
% of (Applicable) Behaviors Performed	90.4	12.1
Call 5 (5 weeks)		
No. of Behaviors Performed (Adjusted)	13.7	1.7
% of (Applicable) Behaviors Performed	91.2	11.5
Call 6 (8 weeks)		
No. of Behaviors Performed (Adjusted)	13.9	1.6
% of (Applicable) Behaviors Performed	92.4	10.6

Significant $F(6,444)=91.24$, $p \leq .001$ based on results from a repeated measures analysis of variance. The number of behaviors performed (or % of applicable behaviors performed) significantly ($p \leq .01$) increases after each successive call.

Exhibit L. Receipt of protection order status for 75 intervention women compared to 75 control group women.

	Intervention		Control		Total	
	N	%	N	%	N	%
Received Protection Order	42	56.0	39	52.0	81	54.0
Did Not Receive Protection Order						
Women Dropped	20	26.7	20	26.7	40	26.7
Perpetrator never Served	9	12.0	9	12.0	18	12.0
Case dismissed by DA:	4	5.3	7	9.3	11	7.3
Incomplete		(3)		(3)		
PO contested & judge dismissed		(1)		(1)		
Woman no show				(3)		

The 42 protective orders, or 56%, received by the intervention group were not significantly higher (Π^2 (1)=0.242, p=.623) than the 39 protective orders, or 52%, received by the control group.

The reasons the women did not receive a protection order were not significantly different (Π^2 (1)=0.242, p=.623) between the intervention and control groups.

Exhibit M. Number of days from application to receipt of protection order (PO).

Number of Days from Intake	Intervention			Control		
	N	M	SD	N	M	SD
Days to PO Secretary	72	1.5	2.7	70	1.4	2.6
Days Application Typed	71	4.7	3.3	70	5.2	3.5
Days to PO Prosecutor	71	4.7	3.3	70	5.2	3.5
Days Back from PO Prosecutor	71	4.9	3.3	69	5.5	3.5
Days File Copied	68	7.2	3.1	69	7.6	3.3
Days Filed in Court	68	7.3	3.1	69	7.7	3.2
Days Service Papers Received	66	11.9	5.4	68	11.2	3.3
Days Serve Papers to Constable	66	12.2	5.5	68	11.7	3.2
Days Perpetrator Served	51	16.0	8.5	53	15.0	5.5
Days from Intake Woman Received PO	41	24.5	9.1	39	24.7	8.5

$F(8,70)=1.735$, $p=.106$