# "A RURAL RESPONSE TO INTIMATE PARTNER VIOLENCE"

A MAINE PILOT PROJECT
1996 - 2002

## FOUR LINKED RURAL PROJECTS BASED ON THE COORDINATED COMMUNITY RESPONSE MODEL

## FINAL REPORT
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# A Rural Response to Intimate Partner Violence
# Maine's Pilot Coordinated Community Response Project
# 1996 – 2002

## Final Report

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## Introduction

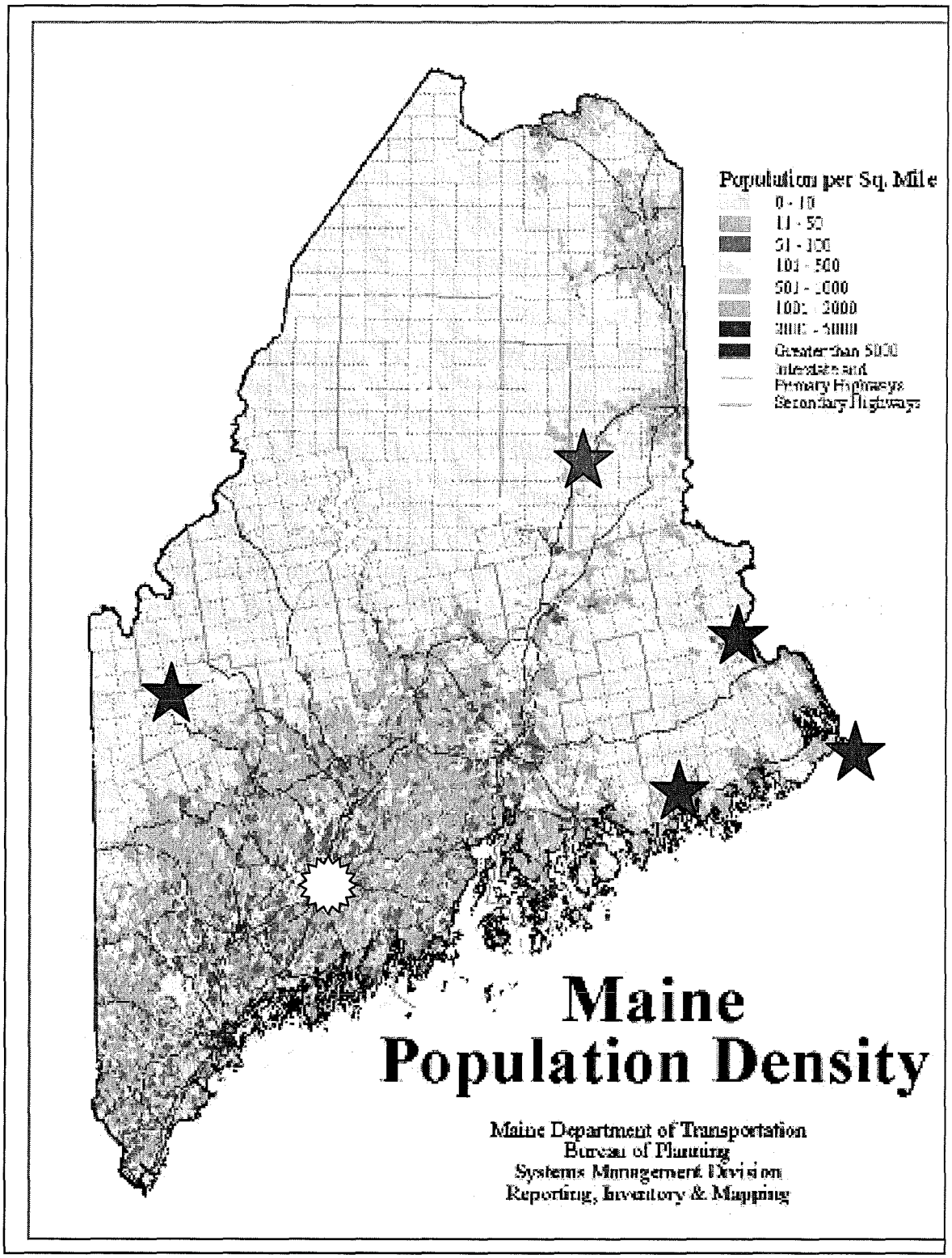
*Small, isolated communities usually lack the resources and infrastructure to develop effective community coalitions, but utilizing a large geographic area as a "community" to capture a population large enough to support the necessary infrastructure results in trying to bring together people who do not view themselves as members of the same community.*

*From the proposal, 1996*

This was the dilemma faced by Maine's rural communities in 1996. The Rural Response to Intimate Partner Violence was a six-year pilot project, beginning in October 1996 and ending formally in September of 2002, that aimed to resolve the dilemma through a "unique model for developing and operating community coalitions" in rural areas. The target outcome was a coordinated community response, where the responsive community was a cluster of towns, whose common efforts to address the problem of intimate partner violence would be mediated by a community coalition, which would be supported in turn by another mediating institution, the regional community health center.

The program was managed from the state capitol, Augusta (rosette on map, Page 2), by the Maine Primary Care Association (MPCA), which is the state association of Federally Qualified Health Centers. Until a formal name change in early 2002, MPCA was known as the Maine Ambulatory Care Coalition (MACC). Because all the original project materials for the period 1996 through early 2002, many of which will cited for this report, use the MACC designation, the two acronyms, MACC and MPCA, will be used interchangeably.

Primary care associations are nonprofit entities created in each state to support community health centers, which provide primary care to medically underserved and uninsured persons, under the terms of Section 330 of Title III of the Public Health Service Act. The system is overseen at the federal level by the Bureau of Primary Health Care (BPHC) of the Health




**Location of Rural Response Program Sites, Control Site, and Headquarters**

Resources and Services Administration (HRSA) of the Department of Health and Human Services (DHHS).

Project activities were carried out at four sites (red stars on map). During the implementation phase (the second three-year grant cycle), a control site provided a point of data comparison for evaluation purposes (blue star). All five communities involved in the project were sites of community health centers, which provided local administrative support and oversight for project activities. All health centers hosting local coalitions were organizational members of MPCA and had been recruited by MPCA to be participants in the project. Maine's demographics, in conjunction with the mission of the health center system, ensured that project sites were located in very rural areas.

Selection of the four project sites was by self-election by administrators and other staff at the local health centers. This method, which was necessary to ensure optimal organizational readiness and capacity to support program success, resulted in a geographic distribution of sites that had unplanned consequences. Three of the program sites are in a single county (Washington County), an area served by a single DV victim services agency, a key local partner. As a result, these three projects collaborated on a number of initiatives and were able, working together in this way, to have a regional impact. In addition, the staff for each project had colleagues fairly close at hand for consultation and support.

In contrast, the fourth project was located in the western mountains (Franklin County), in an area remote, not only from the other projects and from the MPCA office, but also from the nearest DV services provider agency and the health center's own central administration. This isolation affected staff morale, resource availability, opportunities for interagency collaboration, and other factors that influenced coalition progress and effectiveness.

These contrasts, although not planned, provide an opportunity for some learnings which we will hope to bring out later in the report.

# Section I

## Community Characteristics

*Characteristics of the intervention community and comparison community before funding:*

- *Sociodemographics: population size, concentration (urban / rural), main economic activities, SES, level of education*
- *Prevalence or incidence of IPV, possible determinants*
- *Existing services & programs for IPV prevention or treatment before funding*

Information on the four sites follows. Although there are some variations, the similarities are marked, painting a consistent picture of isolation, poverty, and violence. As a concomitant to the marginalization of these communities, there is a shortage in each of them of the kind of agency with the independent resources and motivation to supplement government-required data-gathering activities. Consequently, certain kinds of information have always been in short supply. Data that is collected may only be gathered periodically and the most recent data may be five or ten years out of date. Occasionally, where there is data, it contains discrepancies that are not possible to reconcile after the passage of many years.

Because there are four program sites, instead of one, a couple of considerations apply. In a limited sense, it may be well to think of this project in terms of a statewide program, rather than as a strictly local one – limited because, since all the sites are rural areas, it cannot be assumed that any of the results are applicable to urban environments.

With respect to the areas involved for calculating the population affected, it will be helpful to remember that one of the propositions being tested by this project is that institutional mediators (schools, health centers, coalitions) can create metacommunities that in certain respects function in the same way that a normal community would in providing residents with a sense of belonging and identification and with a mechanism for meeting some of their practical needs. In other words, the theory is that attachment exists to entities beyond the town that mimics the attachment that one feels to the town itself, and that that attachment has both pragmatic and romantic elements.

In a general way, this notion should not seem counterintuitive, since it is no different in concept from the chauvinism we are capable of feeling for

our state and for our nation, entities with which our connection is a good deal more abstract and remote than is that with our own neighborhood.

In a more concrete sense, however, people in Maine have seen this principle at work for years, ever since school consolidation made it necessary for people from small towns to band together to perform the function that, for most, is the central purpose of local government, the number one reason for sublimating some personal preferences to the exactions of the group, the education of their children.

**State of Maine**

- *Population*

  The state population in 1996, according to the US Census Bureau and the Maine State Office of Data Research & Vital Statistics was about 1.2 million.

- *Concentration (urban / rural),*

  As the population figures suggest, these areas are rural and, for the most part, quite thinly populated. Their remoteness and isolation contribute to the challenges faced by the project, through a shortage of services and a lack of opportunity for social interaction. On the other hand, if one does seek help in such small communities, it is difficult to do so in an anonymous way.

- *Economic activities*

  All participating regions are dependent on low paying seasonal labor, including tourism and several natural resource based industries.

- *Socioeconomic Status*

  On most measures, these areas compare unfavorably to the state as a whole. There is a phrase, current in modern political discussions, that captures the tenuous economy and marginal economic status of this enormous area in the western, northern and eastern parts of the state: it is called "the other Maine".

- *Education levels*

  Maine has a high rate of graduation from secondary school and a low rate of matriculation for post-secondary education. This paradox has

been the focus of educational policy discussions for the last several years.

- *Prevalence or incidence of IPV & possible determinants*

  Maine's reported rates of domestic violence, at the beginning of the project, were similar to those for the nation as a whole.

- *Existing services & programs for IPV prevention or treatment*

  The principle agents for IPV work in Maine were the local DV services providers, supported at the state level by the Maine Coalition to End Domestic Violence. This network had, for two decades, been providing a range of services to victims of DV, including hotlines, shelters, court advocates, support groups, and community education and outreach. There are ten local programs in the state, leaving large citizens, predominantly in rural areas, without ready access to their services.

## Rangeley Area

- *Population (1996)*

| | |
|---|---|
| Dallas Plantation | 165 |
| Eustis | 685 |
| Lincoln Plantation | 35 |
| Madrid | 166 |
| Magalloway Plantation | 40 |
| Rangeley | 1073 |
| Rangeley Plantation | 107 |
| Sandy River Plantation | 65 |
| TOTAL | 2336 |

  This figure grows to an estimated 8,000 to 10,000 in the summertime, when summer people and tourists are in residence or passing through.

  The population is ethnically homogeneous: 99% are of Caucasian descent.

- *Concentration (urban / rural)*

  As detailed above, the largest population center in the area, Rangeley, had less than 1,100 people in 1996 – little more than a village by the standards of most Americans. Organized townships range downward from there, to Lincoln Plantation at 35. The region is 45 miles from

the nearest city up a steep, twisting mountain road. In the winter time, this road is sometimes impassable for a day or more at a time.

The "Practice and Service Area Profile" produced by MPCA to support the clinician recruiting efforts of the Rangeley Region Health Center has this to say:

> The most striking geographic characteristic of the Rangeley area is its rural setting and isolation from the rest of Franklin County, particularly its distance from the centers of population within this rural county. It is 35 and 45 miles respectively further north than the outlying health centers in Strong and Kingfield, which serve the northern tier of Franklin County. Travel to these health centers or to the nearest hospital in Farmington, 46 miles to the south, is over winding and difficult terrain via mountainous secondary roads. The isolation and remoteness of Rangeley and its surrounding area has historically been a significant barrier in attempting to meet the health care needs of its population.

- *Economic activities*

Tourism has been the mainstay for this area for many years. The lakes and mountains attract summer people, and the population grows from 2,300 to an estimated 8 or 10,000 in the summer. This kind of seasonal swing creates significant stresses both on the physical infrastructure of the area and on social cohesion. The jobs are temporary and low paying, and the continual contrast between residents' and visitors' lifestyles has a corrosive effect on morale.

Other jobs available in the area were mostly in "woods work", harvesting and transporting timber for lumber and pulp, with the vulnerability to any instability in the overall economy or changes in technology that is characteristic of natural resource dependent industries. There was very little value-added manufacturing activity in the area.

- *Socioeconomic Status*

Per Capita income in 1996 was $10,800, 17% below the state average of $12,957. Almost a quarter of the population (24%) subsisted below the federal poverty level. Unemployment was 10.5%, 40% higher than the state average.

- *Education levels*
  Over a quarter of the population of this area (26%) had less than a ninth grade education and less than a third (31%) had completed high school. Less than one fifth (19%) had achieved a bachelor's degree. With respect to this latter statistic, however, it is worth noting that the proportion of Rangeley residents with a college degree was more than twice as high as that of any of the other areas in which the project operated. The context for this situation is that Maine policy-makers have been confounded for many years by the fact that, although the proportion of Maine youth that graduates from high school is among the highest in the nation, the number going on to post secondary education is among the lowest.

- *Prevalence or incidence of IPV & possible determinants*

  Consistent hard data on DV was not being kept in 1996 by law enforcement or court officials or medical providers. The Abused Women's Advocacy Project (AWAP), the DV victim services provider agency within whose territory Rangeley falls, maintains data on their contacts with clients, but at this time had almost no presence in the Rangeley area.

  Anecdotal data collected by health center staff seemed to suggest that the area around Rangeley had more than its share (in terms of proportion of the county population) of arrests in which DV was considered a factor by the arresting officer (Maine has a mandatory arrest law). Because of the area to be covered, response time by the Sheriff's Office was relatively slow. Response delays appear to have been associated, at least in the view of the Sheriff's Office, with a high percentage of DV charges dropped, or pleaded down.

- *Existing services & programs for IPV prevention or treatment*

  In 1996, AWAP had no staff stationed in Rangeley. The nearest shelter and focus group activity was in Farmington, 46 miles away over steep and treacherous mountain roads. A counselor had recently been hired at the health center, providing a new resource for referrals, but there was no outreach or community education in place.

***Note on Washington County***

*The other three program sites are all located in Washington County. The Lubec Service Area Profile notes that "with a population of about 35,000 in an area 2.5 times the size of the state of Rhode Island, [the county] is the poorest in the state, and one of the poorest in the nation, often referred to as the "Appalachia of New England"."*

## Harrington Area

- *Population*

  The Harrington Family Health Center serves approximately 5,000 people in the nine towns of Addison, Beddington, Cherryfield, Columbia, Columbia Falls, Deblois, Harrington, Milbridge, and Steuben. 99% of permanent residents are of Caucasian descent, although substantial numbers of Hispanics and Native Americans spend a month or more in the area during the blueberry harvesting season.

- *Concentration (urban / rural)*

  The area is rural, with three towns between 1,100 and 1,300 population and two under 100. The two nearest hospitals are 22 miles east, in Machias, and 50 miles south, in Ellsworth. Machias is the county seat of Washington County, and itself has a population of under 3,000.

- *Economic activities*

  Most work in the area is seasonal. The most important employment opportunities are in tourism, fishing, raking blueberries, digging clams and marine worms (for bait), and making Christmas wreaths. Blueberry harvesting is accomplished in large measure by migrant workers from out of the area (mostly Native Americans from Canada and Hispanics from further south), of whom the Service Area Profile notes, "The migrant population which visits the area during the summer is one of the poorest groups in the nation, bringing with it the common companions of extreme poverty such as lack of regular health care, chronic disease, and the interpersonal pathologies resulting from the stresses of deprivation."

- *Socioeconomic Status*

Per capita income in 1996, at $8,579, was only two-thirds of the state average and the lowest of any area served by the project. 24% of residents lived below the federal poverty level, and 15% were unemployed, the highest rate of any area served by the project and twice the state average.

- *Education levels*

  59% of residents had never completed high school (9% had less than a ninth grade education), and only 9% had completed college.

- *Prevalence or incidence of IPV & possible determinants*

  The social worker at the Harrington Family Health Center reported: "Approximately 50% of the women I treat in my mental health practice have suffered or are suffering from abuse. Many have been abused as children and are now suffering post-traumatic stress disorder; others are currently being abused mentally, physically or verbally. Rates of depression among these women are very high and some succumb to drug or alcohol dependency. In many instances, abused women are unable to protect their own children because of fear of the abuser. ... Among the children I treat, many have been abused physically or sexually ...Abused children suffer from anxiety, depression, learning problems and behavioral problems. Rigid gender stereotypes, along with unemployment, poverty, and isolation, characterize this community, and these problems likely contribute to the pervasive presence of IPV."

- *Existing services & programs for IPV prevention or treatment*

  WomanKind, the local DV victim services provider agency, maintained an emergency shelter in Machias (22 miles away) and a hotline.

**Lubec Area**

- *Population*

  The Regional Medical Center at Lubec serves approximately 4,000 in the eight towns of Cutler, Dennysville, Lubec, Plantation #14, Trescott, Whiting, and Campobello Island, New Brunswick, Canada. Over 98% of the population is of Caucasian descent.

- *Concentration (urban / rural)*

The area is rural. Lubec itself has a population of 1800. All the other towns in the area are at less than 800. Lubec is the eastern-most town in the US and the sea plays a major role in both the economy and in the consciousness of the people. It is reported that there are still residents of the area, of all ages, who have never been to the nearest city, Bangor, two and a half hours away by car, and even some who have never been an hour's drive to the county seat.

- *Economic activities*

  "Chronic unemployment is relieved sparingly by low-paying seasonal work without benefits, such as fishing, sardine packing, working, wreath-making, blueberry harvesting, and some clamming and woods work." (Service Area Profile)

- *Socioeconomic Status*

  In 1996, per capita income was $9,070, 30% below the state average. 22% of the people live below the poverty rate, and 9% are unemployed.

- *Education levels*

  42% of area residents have graduated from high school. 9% have a bachelor's degree. 12% quit school before reaching the 10th grade.

- *Prevalence or incidence of IPV & possible determinants*

  In 1996, no municipal level or data was maintained, but the Uniform Crime Report of the Maine Department of Public safety recorded 107 reports of domestic violence assaults during the period 1991 – 1994. On the other hand, WomanKind, the DV victim services provider agency, served 284 women in its shelter in 1994.

- *Existing services & programs for IPV prevention or treatment*

  Apart from the services of WomanKind, which included an emergency shelter, an emergency hotline, support groups and individual counseling, Washington County was served at this time by a batterers intervention program called Metanoia. Apart from the hotline, these services were over 30 miles away from the Lubec area, as were the nearest hospital emergency room and the nearest mental health provider.

## St. Croix Area

- *Population*

  The St. Croix Regional Family Health Center serves approximately 4,600 people in the 14 towns of Alexander, Princeton, Baileyville, Talmadge, Crawford, Vanceboro, Grand Lake Stream, Waite, Plantation #21, Fowler Township, Lambert Lake, Dyer Township, Kossuth Township and Township #27. 98% are of Caucasian descent and the rest are Native American.

- *Concentration (urban / rural)*

  The region is extremely rural, being heavily forested throughout. Baileyville, the site of a major paper mill in 1994, had a population of almost 2,100, but all the other towns in the area ranged downward from 1,000 (Princeton, the site of the health center) to less than 60 (Talmadge). The service area of the St. Croix health center surrounds Indian Township, one of the reservations of the Passamaquoddy Tribe, which is served by its own health center. The nearest hospital in Calais is only 20 miles from the health center, but as much as 50 miles from the outlying towns in the area.

- *Economic activities*

  The largest employer in the area is the Georgia-Pacific paper mill in Baileyville. In addition to those who work in the mill itself, many residents are employed doing the logging and trucking that keep the mill running. All of these jobs are subject to seasonal variations and cyclical fluctuations in the demand for paper. There is some work in the tourist trade.

- *Socioeconomic Status*

  In 1996, per capita income in the area was calculated at $10,847, the highest of any of the areas served by the project, but still 16% below the state average. 14% of the people lived below the poverty line. Unemployment, at 7%, was the lowest of any of the areas served and the only local rate that was actually below the state average of 7.5%.

- *Education levels*

48% of area residents had graduated from high school in this period, the highest rate of high school graduation of any area participating in the project, but only 6% had earned a bachelor's degree, which was the lowest rate. 11% had less than a 9th grade education.

- *Prevalence or incidence of IPV & possible determinants*

  In responses to a questionnaire administered by the health center, female patients reported that they had been abused verbally, physically, or sexually, at some time in their lives, at rates of between 46% and 57%, depending on the type of abuse. In 18% to 38% of the cases, the abuse had occurred within the previous 12 months.

- *Existing services & programs for IPV prevention or treatment*

  WomanKind, the DV victim service provider agency, located in Machias, is between one hour and two hours away from towns in this area over poorly maintained secondary roads. The nearest hospital emergency room, in Calais, is between 20 and 50 miles away, depending on which town you measure from.

**Katahdin Valley**

The Katahdin Valley Health Center became the comparison site for the project in 1999. Most of the information collected in 1996 for purposes of the application did not include KV data. The current Service Area Profile, which dates back several years, includes the following information:

- *Population*

  The health center serves about 4,500 people in the ten towns of Benedicta, Crystal, Dyer Brook, Hersey, Island Falls, Moro, Mt. Chase, Patten, Sherman, and Stacyville. The population is 99% white, with most of the rest being Native American.

- *Concentration (urban / rural)*

  Patten has a population of about 1,100. Moro's is less than 40. The area is connected by Interstate 95 to Houlton, half an hour to the north, and Bangor, Maine's third largest city, an hour and a half to the south.

- *Economic activities*

  The area benefits from its proximity to Mount Katahdin, the terminus of the Appalachian Trail, and Baxter State Park, a popular tourist destination. Tourism and recreational activities are the biggest source of employment opportunities. Woods work is also a significant employer, with a number of paper and lumber mills in the general area.

- *Socioeconomic Status*

Per capita income in the area was $10,028, comparable to Rangeley and St. Croix. 16% of residents lived below the poverty rate and unemployment was at 11%, the same as Rangeley.

- *Education levels*

  Data not found.

- *Prevalence or incidence of IPV & possible determinants*

  Unknown

- *Existing services & programs for IPV prevention or treatment*

  The nearest services for DV victims, other than counseling services provided by the health center, are in Bangor, and hour and a half to the south, and in Presque Isle, an hour and a half to the north, where the nearest DV victim services agencies are located.

## Section II

## Goals & Objectives

*Initial goals and objectives, changes, and why the goals and objectives changed*

*N.B. – Records for the beginning of the first grant have not been as easy to locate as those from more recent years. It is possible that we may be able to elaborate more fully if further digging turns up additional material.*

The original application for funds, dated 8/2/96, stipulated the following goals and objectives:

| | | |
|---|---|---|
| **Goal 1** | **Maine communities served by four rural health centers will develop a coordinated community response to intimate partner violence.** | |
| | Obj. 1.1 | Four community coalitions will develop primary prevention programs to dispel misconceptions about IPV and to change attitudes, beliefs, and behaviors that cause or promote IPV. |
| | Obj. 1.2 | Four community coalitions will develop and implement programs to enhance the services for and support to women who are victims of IPV. |
| | Obj. 1.3 | Four community coalitions will develop and implement treatment programs for victims of IPV. |
| | Obj. 1.4 | Individuals in four communities will receive training, education, and information about IPV. |
| **Goal 2** | **[MACC will provide] an effective structure to support the efforts of local community coalitions addressing intimate partner violence.** | |
| | Obj. 2.1 | MACC will assist four community coalitions in designing and implementing primary prevention programs to dispel |

| | | |
|---|---|---|
| | | misconceptions about intimate partner violence and to change knowledge, attitudes, beliefs, and behaviors that cause or promote IPV. |
| | Obj. 2.2 | MACC will assist four community coalitions in developing and implementing programs to enhance services to support women who are victims of IPV. |
| | Obj. 2.3 | MACC will assist coalitions in developing and implementing treatment interventions for victims of IPV. |
| | Obj. 2.4 | MACC will deliver training in intimate partner violence prevention, identification, and intervention to coalition members and provide assistance to four coalitions in providing training, education, and information to community members. |

The parallel structure of the strategies specified for the two goals shows the complementary roles envisioned for the local community coalitions and for MACC. The coalitions were to be responsible for developing and implementing local strategies, with on site support from the community health centers. MACC would, at the state level, provide coordination, support, and technical assistance for the local efforts.

In view of the recent emphasis on restricting project activities to prevention, the intervention and treatment activities specified in the second and third objectives under each goal would appear to reflect an initial misunderstanding of the intended scope of project activities, or perhaps a less clearly focused purpose on the part of CDC. As will be discussed elsewhere, this overbroad delineation of project scope brought the local coalitions into conflict with local DV victim services provider agencies and the state wide DV coalition. This was one of several frictions that had to be addressed by the project over its life, and which was still showing residual effects in the project's final days. Any correspondence on this issue between CDC and MACC appears to have been lost, but we may infer that there was some, because in the final formulation of the objectives, as reflected in the Year One progress report, Objective 1.3 was changed to read:

Obj. 1.3: Four community coalitions will develop and implement empowerment/support programs for victims of IPV.

Oddly, the change of focus from "treatment" to "empowerment/support" is not, in this case, paralleled in Objective 2.3, which still refers to "treatment interventions". This configuration of goals and objectives remained the basis of project activities throughout the first three-year grant cycle.

For the second three-year cycle, reflecting the shift in funding focus from program development to implementation, as well as the maturity of the project, the new goal set looks quite different, expanding the number of goals from two to four, adding a focus on evaluation, and refining the focus and specificity of the objectives:

| | | |
|---|---|---|
| **Goal 1** | **Four coalitions will integrate prevention strategies and services through increased coordination, communication and cooperation among a broad range of community sectors.** | |
| | Obj. 1.1 | Four coalitions will have an increased quantity, frequency and quality of participation in coalition activities by both coalition and other community members. |
| | Obj. 1.2 | Four coalitions will increase the networking among community agencies directly and indirectly involved with IPV. |
| **Goal 2** | **Participating communities will have sufficient prevention and intervention services and individuals in these communities will have access to those programs and services.** | |
| | Obj. 2.1 | Four communities will have increased primary prevention programs. |
| | Obj. 2.2 | Four communities will have increased interventions and services for those affected by IPV and increased utilization of those services. |
| **Goal 3** | **[MACC will provide] an effective structure to support local community coalitions addressing IPV.** | |
| | Obj. 3.1 | MACC will assist four community coalitions in integrating prevention strategies and services through increased coordination, communication and cooperation among a broad range of community sectors. |
| | Obj. 3.2 | MACC will assist coalitions in assuring that participating communities will have sufficient prevention and intervention services and individuals in those communities will have access to those programs and services. |

| | | |
|---|---|---|
| **Goal 4** | **Four communities will implement comprehensive strategies for tracking, evaluation and dissemination.** | |
| | Obj. 4.1 | MACC will provide four communities with an increased capacity to track and analyze victim reports of IPV and/or reported IPV incidence and prevalence in the community. |
| | Obj. 4.2 | Four communities will have comprehensive strategies developed and implemented for evaluating IPV programs and services and there will be increased use of evaluation to guide and improve program activities. |
| | Obj. 4.3 | Four communities will have increased data collection and analysis across various sectors including criminal justice, health care, insurance, social services and businesses. |

Goals 1 and 2 continue the focus of the original Goal 1, which was on the development of a coordinated community response (CCR). The original goal set identified the creation of local coalitions as the keystone of that response. The new goal set approaches the CCR concept in a way that addresses several underlying issues, both of process and impact, more explicitly. For instance, the new Goal 1 deals with outputs, whereas the new Goal 2 addresses outcomes. Consequently, Goal 1 objectives deal with process, both of the coalitions themselves and of other entities affected by their activities, whereas those for Goal 2 deal with the intended results of those processes, measured in terms of changes to the local infrastructure for prevention, intervention and services.

Goal 3 continues the focus of the original Goal 2 on MACC support, both in maintaining healthy coalition process and in achieving the target infrastructure changes.

Goal 4 introduces a new focus on data collection, analysis and reporting. While this focus area had been addressed explicitly in the proposal for the first funding cycle (Program Development), both in the narrative and in the budget, it had been ancillary to, and supportive of, other activities framed as the primary focus. Here (Program Implementation) evaluation becomes an equal focus of the project. The project now exists, not only to create change, but equally to understand and report that change.

## Section III

## Building a Coalition

**Coalition** – A temporary alliance of distinct parties, persons, or states for joint action. *[Webster's 9th Collegiate Dictionary, 1984]*

In the social services during recent decades, the C words have been tossed around with great abandon: Coordination, Cooperation, Collaboration, and Coalition. There is a constant muttering about the distinctions among these terms. There is a general notion that working together is a Good Thing, a notion that it is politically incorrect to dispute, and yet there always seems to be some reason why it is more difficult to pull off than it ought to be, given the proclaimed consensus.

One often overlooked fly in the ointment is that, for two parties to work successfully together, on any level, each has to give something up *to the other* – including, among other things, a measure of power and control: over decision making, over execution, and hence, over outcomes. Many partnerships founder on this hidden shoal that, if it were better mapped, might manage to navigate around it.

The transient nature of coalitions offers a partial balance to the threat they pose. If goals are specific and limited, trust need not be absolute and forever. Loss can be contained. The trade-offs can be predicted and evaluated.

There is a presumption, however, reflected in the recent obsession with organizational "sustainability", that joint enterprises should not be begun unless they can be maintained in perpetuity. Because sustainability is made a criterion for success, many grant-funded efforts at social action are branded failures, because the free market will not sustain them in the same form that the initial grant required them to take.

This presumption may be especially insidious in cases where the problem is deeply entrenched and the goal of collective action proportionately elusive. Intimate partner violence, as one example, is both poorly understood and clearly rooted in our psychology and our culture. On both grounds, the campaign to control the violence will inevitably be long. Therefore, the natural temptation is to create durable structures to wage it.

Yet the obligation to create a sustainable *organization* may distract community organizers from legitimate opportunities and may discolor an observer's assessment of their actual achievements. In this case, a requirement of the grant has been for the coalitions to locate funds to support their continued activity. A better focus might have been on looking for existing structures that might continue to support the work of the project in the community.

The health centers, for instance, are one durable institution, that could play such a role. Continued health center support is a possibility on a reduced level at some sites, but there was no deliberate campaign to make the most of this or other similar opportunities. As a result, in the absence of substantial local funding, which was sought, but not found, all coalitions have been forced to reduce their level of activity.

**Who were the members?**

There was both method and serendipity in the recruitment of coalition members. While categories of representation were used as a recruiting guide, the persons approached were predominantly those personally known, first to the Local Project Manager (LPM) and later to coalition members. Once the coalitions began to put on major events, these occasionally resulted in the enrollment of new members, but they were self selected.

Probably the most methodical recruiter was the Carriage House Coalition at the Harrington Family Health Center. Their membership spanned the following 14 categories:

1. Law Enforcement/Courts
2. Education, K-12
3. Education, Post Secondary
4. Health Care, Clinical
5. Health Care, Admin & Tech
6. DV/SA/BIP service providers
7. Counselors
8. Other Nonprofit Providers
9. Clergy
10. Business People
11. Government Employees
12. Students
13. Artists
14. Other interested community members

The other coalitions also recruited in these categories, but ended up with smaller and less comprehensively representative groups. In some cases this resulted from a different emphasis. In others, they were unable to find

willing participants to represent certain interest groups. In addition to these categories:

15. Two towns recruited the town librarians
16. One coalition identified some of its members as Victims, Survivors, or Witnesses.

Three categories were especially popular. All four local coalitions included representatives of:

- Law Enforcement/Courts
- Health Care, Clinical
- Counselors

Occasionally an oversight would become apparent – someone or some group should be at the table that hadn't been thought of previously – at which time personal contacts would be made to fill the gap.

By the time the coalitions had matured, at the end of the first three years, the coalitions ranged in size from 13 to 30. (See Coalition Membership Lists in Appendix H)

Organization of these coalitions was typically quite simple. Three coalitions identified the LPM as the coalition leader. One of these also identified three coalition members as "Co-Leaders". The fourth identified two members as its Co-Leaders.

Each coalition operated as a committee of the whole most of the time. Individuals might take on specific tasks in organizing an event, or two or three form a *de facto* task force to get something done, but none of the coalitions created a permanent committee structure.

**Strategies used to engage and maintain membership?**

The primary strategy used by LPMs to keep members engaged was frequent personal contact by staff. Members working on a particular project were, of necessity, in constant contact with each other and with their LPM. In addition, however, the most effective LPMs were continually touching base with their members.

The content of those contacts was critical. The contacts were always about something real – a meeting coming up, a project that needed work done. In addition, at meetings, the message, both explicit and implicit, was, "This is your coalition. Your ideas matter. What we focus on and what we tackle is going to be decided by you."

LPMs apparently did not obsess about getting full attendance at every meeting. It was more effective to realize that not everyone was able to make

every meeting and not to put pressure on them to attend if attendance was not critical. At Harrington, for instance, the LPM called every board member prior to every meeting and discussed the agenda and recent program developments in detail. This meant that the member could assess the importance of attending that particular meeting. This practice also had the effect that, since everyone was fully informed about recent progress before each meeting began, it was possible to get right to the business at hand. Meeting time could be used more effectively. On the other hand, LPMs found that, in the event of a planning retreat, a major event, or a meeting at which specific work would be done for which all hands were needed (like hand addressing envelopes for personal invitations to an event), most members could be relied upon to show up.

We should not overlook the foundation for recruiting committed community members, for which this ongoing contact was merely the logical follow up. LPMs, and later on, coalition members also, made a point of attending a lot of community events, whether or not they had any direct relation to project goals and activities. In this way, they became more widely known in their communities, and specifically, more known as community activists. In time, this translated into a broad community awareness of the project and its work, a willingness to trust the project and its staff, and a belief that the project would get things done.

One challenge to be overcome in engaging coalition members arose from constraints put on the project by the funder. In the first three year grant cycle, for instance, it was a condition of the grant that the work focus on adults, not children. Almost all coalition members felt that this was an illogical and unreasonable restriction – that true prevention required integration of the upcoming generation into their community development activities. When the Bridge Coalition formed spontaneously at Narraguagus High School in Harrington, creating an extraordinary opportunity to advance the specific ends of the grant, the coalition was even restricted in the way they could react to support the students. Fortunately, the restriction was relaxed somewhat in the second cycle. It was never made clear to the local volunteers, however, why they were denied local control in this crucial matter.

**Evidence of Success?**

The major impact of coalition activities, as designed, was expanded community awareness. Prior to the inception of the project, family violence was never discussed openly in any of the program communities. It was not even talked about at the health centers.

By the end of the project, active screening was a part of all health center protocols, although more effectively integrated and practiced in some than in others. Collaborative efforts to solve community problems were underway, that had no local precedent. Local businesses, schools, and media outlets were all partners in distributing information and addressing the issue of community values.

In 2002, a woman fell off a cliff in Quoddy Head State Park. Her husband reported the accident. Within half an hour, the Sheriff's Office was investigating the incident as a possible homicide. Respondents to an informal poll were unanimous in concluding that, five years before, it would never have occurred to anyone that the man's story might not be the simple truth.

In Washington County, a Batterers Intervention Program exists today – its first clients began classes in April 2003 – that would not exist without the aggressive and persistent advocacy and legwork of a coalition organized by the three LPMs from Harrington, Lubec, and St. Croix.

In Harrington, the health center transferred the LPM into a permanent position (Manager of Care) with the provision that part of her time could be used to continue support of the coalition's activities. In Rangeley, where the LPM was retained on staff, but not allowed worktime to support the coalition, the coalition has selected two of its most successful events to continue as annual events, working on a volunteer basis. The LPM has joined the coalition as a volunteer member.

For results of the Coalition Participant Survey, see Section 6 – Impact.

# Section IV

# Activities

Maine's project involves four program sites and one comparison site, all located at community health centers in rural areas. Community health centers are community-controlled health care facilities that provide primary care services without regard for one's ability to pay. Each is located in a federally designated Medically Underserved Area (MUA).

At each program site, a community coalition was formed, with staff support provided by the health center through a subgrant from MPCA. In addition, the Local Project Manager (LPM), with support from MPCA, supported local clinicians in taking a more proactive stance in addressing the possibility that patients' medical conditions have been precipitated or aggravated by experience with abuse.

Project activities were carried on simultaneously at the local level and at the state level. At the local level, each of the four program sites began their activities in a similar way, operating under a generic plan developed as part of the original proposal, and diverged gradually as their coalitions matured and as differing local circumstances and perspectives became increasingly influential.

For specific evidence of program impact, see Section 6 – Impact.

**Comparison Community (Katahdin Valley Health Center)**

During the project period, no coalition to address DV issues was formed in northern Penobscot County or in Southwestern Aroostook County (Patten/Island Falls area). The area is remote from all of the local DV service provider organizations, and so far as we know, no community education or community-based prevention activities were carried out in this area. It is possible, though in our experience unlikely, that some DV education was included in health education classes. The state Learning Results policy mandates that each school have a comprehensive health education curriculum in place, but domestic violence is not currently one of the topics required for inclusion in the curriculum.

## Year One (1996–97)

The designed focus of year one was developing local coalitions and "assisting and supporting them" in assessing the scope and profile of local needs and in planning intervention strategies for responding to those needs.

At the local level: in all four project locations

- The Community Health Center hired a part time Local Project Manager (LPM) [these positions were increased to full time in the second grant cycle];
- The LPM established a CQI protocol and introduced it to clinicians[1];
- The LPM began recruitment of coalition members;
- Coalition members attended trainings provided by MPCA at both the state and local level; and
- LPMs and Coalition members provided input to MPCA for the development of five evaluation instruments for tracking and assessing Coalition activities and impacts.

At the state level:

- MPCA[2] staff oriented CHC administrators and LPMs to domestic violence (DV) issues and to project goals, theories, methods, and constraints;
- MPCA organized a Rural Coalition Advisory Group (RCAG), made up of stakeholder organizations and individuals with expertise in responding to one or more of the challenges faced by the local coalitions and the statewide project;
- MPCA staff conducted state level trainings and on-site trainings on DV and project issues both for local project staff and for local Coalition members;
- MPCA developed a training for CHC staff assigned to serve on local Continuous Quality Improvement (CQI) teams for the project;
- MPCA staff conducted twice monthly site visits to each local project to ensure steady progress;
- MPCA sought out and made arrangements with an Institutional Review Board (IRB) to oversee patient and victim interests during project evaluation activities;
- MPCA staff collaborated with CDC staff in the development of several project evaluation instruments; and
- With input from local projects, MPCA staff developed several additional evaluation instruments for tracking and assessing local Coalition activities and impacts.

[1] "Clinicians" includes physicians, physicians' assistants (PAs), and Nurse Practitioners (NPs).
[2] From the project's inception in 1996 through early 2002, the Maine Primary Care Association (MPCA) was known as the Maine Ambulatory Care Coalition (MACC). We refer to the organization as MPCA throughout this document.

## Year Two (1997-98)

The designed focus of year one was assisting and supporting local coalitions in implementing the intervention strategies developed in year one. The introduction to the Year Two Final Report offers a flavor of the enterprise at that moment in its history:

> ... Rural poverty has not changed. Fish processing plants that once provided work for coastal communities sit like skeletons along the docks; farmers struggle to keep ahead of costs, foresters work long hours in biting cold air, wreath makers feel the steel wire lay tracks in their fingers as they turn balsam boughs into circles of joy and hope...
>
> With the quiet [after the tourists depart]... comes the loss of revenues critical to survival over the long dark months. Work is scarce in the areas surrounding the project sites, stress is high, and despair too frequently erupts in violence between intimate partners... Spring and summer are the seasons when many victims of partner violence bid for freedom, knowing that they and their children will not freeze in the woods at night... Too often the bid for freedom ends in despair at not finding a new place to live, new friends, work, or safety because there is no structure of support in communities.
>
> Throughout the past winter, in spite of a paralyzing ice storm, hazardous roads, and intermittent power and phone systems, the activities of four coalitions have continued forward... If anything, the winter's adversities supported the ingenuity and ability of coalition members to focus on true community resources to carry out IPV prevention and awareness projects. With the arrival of spring... there is time to draw in new community members.

## MPCA

MPCA provided guidance to local projects in the following areas:

- Engaging men in primary prevention activities,
- Approaching school boards and administrators,
- Approaching potential partners in the business community,
- Finding DV-related information on the Internet,
- Production of a locally-developed dramatic presentation on power and control issues in dating relationships,
- Coalition meeting facilitation,
- Responding to community conflict,
- Access to state-level resources relevant to the solution of local problems,
- Model protocols for IPV response and CQI procedures,
- Clinician information sheets,
- Development of training and funding resources, and

- Risk/benefit assessment of proposed coalition activities.

At this point, the different characters of the four coalitions and their host communities began to emerge. One factor that was to have a persistent impact on the rate and style of development of the four programs was the geographical accident that clustered three of the programs and isolated the fourth. The Rangeley program, was an hour's drive (in good weather) from the nearest DV victim services program, the nearest sexual assault response team (SART), the nearest hospital, the nearest university, and the nearest major population center. It was two hours from the MPCA office and five hours from the nearest sister IPV program.

By contrast, the other three programs were all located in Washington County. Although itself a very large, rural, and thinly populated county, the location of three allied programs within a single county allowed it to be treated as a regional unit for some purposes. These three programs were close enough to lean on each other for support in different ways and to draw energy from each other.

On the other hand, major local events could have an impact on all three of these programs. During this second year of the project, there were two such events. The first was the great Ice Storm of 1998 that shut down large parts of the State of Maine for almost two weeks. The second was the loss by the local DV program, WomanKind, of its DHS contract and its resultant demise. The process of finding a replacement victim services provider was protracted and difficult. One consequence was that the three Washington County programs had no local provider on which to rely for referrals, training, and collaboration.

## Rangeley Project for Domestic Peace (RPDP)[3] at the Rangeley Region Health Center

This coalition experienced growing pains during this year. In an attempt to ensure an egalitarian character for the group, the coalition made decisions that led to a lack of clarity about roles, an absence of member accountability, and an excessive reliance on the part time LPM to carry out coalition decisions. With MPCA's help, the coalition addressed these issues through a "back to the drawing board party", which resulted in specific strategies and assignments, a detailed work plan, and a greater sense of ownership on the part of coalition members.

Considerable energy went into working through tensions with the Abused Women's Advocacy Project (AWAP), the victim services provider

[3] Initially known as Citizens of Rangeley Acting Against Violence (CORAAV)

agency for Franklin County, whose nearest office is an hour away in good weather, resulting in some collaboration on school-based outreach and prevention.

A coalition representative traveled to Orlando, FL, to make a presentation to the annual conference of the National Rural Health Association. A clinician at the Rangeley Community Health Center, he told the conference that health center staff "felt they needed to look at their own behaviors in work relationships as a reflection of community beliefs about power and control in addition to participation in community education and awareness of IPV beliefs."

In addition to getting a late start compared to the other coalitions, the Rangeley group found that the heavy local reliance of seasonal income from the tourist trade limited member availability for summer events. This slowed the pace of developing visibility in the community.

## The Washington County Coalitions

During Year Two, as noted above, WomanKind, the Washington County DV service provider agency, lost its contract from the Department of Human Services and subsequently shut down. The annual report for the year includes the following passage:

> The singular, unexpected event that has affected the Rural Response to Intimate Partner Violence Program in Washington County which directly impacts three of [MPCA's] four local projects. The staff turnover, loss of volunteers, loss of public trust in the reliability and unbiased delivery of services culminated during the summer of 1997 in the resignation of the entire WomanKind Board of Directors.
>
> A DHS investigation followed, and the decision to pull the contract was reported in the Bangor Daily News and other media sources on January 1, 1998. The Ice Storm took the lead for news over the next few weeks, and with this delay, DHS extended the period of the then current contract for WomanKind until May 28, to allow for issuance of an RFP and for proposals to be received and reviewed. The 90 day extension added to the county's confusion over the provision of domestic violence services in Washington County. The interim plan developed by a committee of Maine Coalition for Family Crisis Service (MCFCS)[4] members, representing the nine remaining family violence projects, failed to ask for input or involvement from Washington County sectors ...
>
> ... the new grantee has been announced as the Washington-Hancock Community Action Agency. This organization serves as an umbrella agency for a number of low-income programs throughout Washington County. ... Over the coming weeks, [MPCA] anticipates providing significant technical assistance and support to the CHCs, LPMs, and coalitions to address how to inform the community members of the service providers

[4] Now the Maine Coalition to End Domestic Violence (MCEDV)

> for family violence services on a provisional and permanent basis. Discussion and strategy planning have continued among [MPCA], all three coalitions, the community health center administrators, the Maine Coalition for Family Crisis Services, and the Maine state Department of Public Safety regarding this issue, which has helped support the coalitions' efforts to maintain a steady course in activities.

The three coalitions collaborated in trying to bring to county schools a dramatic production called "The Yellow Dress", designed to raise awareness about family violence. Resistance was encountered both from school officials and from parents and teens. The play was ultimately put on in Woodland, Lubec and Machias (but not, at this time, in Harrington). In addition to the performance, this event included facilitated small group discussions for the students. Capping the frustrations attendant on marketing and organizing the event came the publicity from WomanKind taking sole credit for bringing the event to the county.

### Carriage House Coalition at the Harrington Community Health Center

The coalition focused on the following initiatives:

- Outreach to clergy
- Outreach to business community, including a planning breakfast with business leaders
- Summer event focusing on recreational activities and the opportunities they create for empowerment of youth and development of skills for employment in the local job market
- Development of a website
- Poetry for Peace event – student poetry resulting from a partnership with two teachers in grades 8 through 10 – shown at five sites in Harrington, then at the University of Maine at Machias, and finally at the NRHA conference in Orlando, FL.
- CQI team preparation for receipt of IRB approval.
- CDC site visit.

### Safe Harbors[5] at the Regional Medical Center at Lubec.

The coalition focused its energies on the following activities:

- Developing an IPV collection at the town library (overcoming initial skepticism from the librarian)
- The Yellow Dress
- The "Kids on the Block" program to raise elementary student awareness about safe relationships; high school students were

[5] Originally the Quoddy Coalition for Peace Among Partners

recruited to help in the selection of the best program for the elementary grades.
- Development of materials for community distribution: pins, brochures, bookmarks, and cocktail napkins (for bars). All items, in addition to identifying the coalition, carried telephone numbers relevant to victims and survivors: crisis lines, food pantries, Salvation Army depots, etc. Timing of the distribution was coordinated with the tourist season.

Funds[6] for the marketing materials were to come to the coalition through WomanKind. Because of the impending closure, the coalition did not include WomanKind's telephone number on the napkins as originally agreed. WomanKind then decided not to pass the funds through. This decision was reversed after the LPM appealed to DPS with the help of MPCA.

### St. Croix Advocates for Family Peace at the St. Croix Regional Family Health Center

The coalition focused its efforts in the following areas during this period:
- The Yellow Dress Project
- The Town of the Month Project, a community education campaign that focused on a different community each month (there were 12 organized communities in the service area). This effort also involved distribution of pins, cards, bookmarks, pencils, posters, and napkins.
- Development of IPV assessment protocols, and
- Development of a video dramatizing a victim's perspective on surviving in such a remote area.

## Year Three (1998-99)

The projects having matured over the first two years, and having met, in the process, some difficult challenges, the third year was mostly about building on the foundation already laid. Most of the following activities had their genesis in initiatives already begun.
- MPCA developed a model check list of categories for coalitions to use in assuring that all constituency groups were represented in their membership.
- MPCA produced, with material supplied by the coalitions, two issues of the newsletter, The Rural Response, for distribution to health centers, legislators, and other interested parties.

[6] From the STOP Violence Against Women program at the Maine Department of Public Safety (DPS)

- A poster display showcasing the project's evaluation process was presented at MPCA's annual Clinical Symposium and at the annual meeting of the Maine Public Health Association.
- A new collection of material on responding to elder abuse was developed and distributed in collaboration with the Maine State Bureau of Elder and Adult Services.
- With MCEDV, MeCASA[7], and the Maine Children's Alliance, MPCA co-sponsored the "Domestic Violence Services Networking Conference".
- MPCA drafted two articles for health centers to use in their local newsletters.
- The local sites developed new primary prevention initiatives:
  - Lubec – Clergy training using the Broken Vows curriculum;
  - Harrington – Supported development of the Washington County Task Force to coordinate IPV work by all activist groups and organizations;
  - St. Croix – Development of a school prevention curriculum, in partnership with school officials; and
  - Rangeley – A community awareness campaign in partnership with the arts community.
- MPCA organized CQI presentations for health center clinical staff meetings to share progress during the first three years.
- Three health centers engaged in service enhancement projects:
  - St. Croix – Increased access to transportation;
  - Lubec – Increased access to respite or temporary shelter;
  - Harrington – Developed a support network for survivors.
- MPCA identified for coalitions three new funding sources and for health centers an additional 15 possible sources.
- MPCA conducted a training needs survey and identified three new areas of need for coalitions: IPV and the elderly; IPV and the clergy; and fund raising.
- Health Center staff continued with routine trainings on IPV awareness, safety, and legal issues.
- Numerous site visits, training sessions, TA exchanges, and materials purchases kept information flowing as needs were identified.
- The Washington County programs publicized strenuously the new domestic violence project, Peaceful Choices, and its hotline number.

## Year Four (1999-2000)

[7] Maine Coalition Against Sexual Assault

Year Four was also the first year of the second cycle of IPV funding from CDC. The first cycle, administered by the Surveillance Branch, placed a heavy emphasis on needs assessment, the creation of evaluation instruments and development of coalitions. The second cycle, administered by the Program Development Branch of CDC, was more about maturing relationships, stabilizing programs and initiatives, elaborating the most promising strategies, and working toward sustainability of the whole enterprise.

During this period, MPCA conducted two seminal trainings for local coalitions and their partners. The first, on social marketing, made such a profound and lasting impression on coalition members and staff that they immediately revamped their community education materials and strategies and were still talking about the training at the end of year six. The second, a two-day workshop on enhancing the effectiveness of local coalitions attracted a large and diverse group of participants and coincided, fortuitously, with a site visit by the CDC Project Officer and Science Officer.

**Washington County**

The three projects collaborated with DV service providers, law enforcement and judiciary officials, and local legislators, to craft a plan for the Washington County Domestic Violence Initiative, designed to place a dedicated DV Investigator (DVI) in the Washington County Sheriff's Office. Leadership for this initiative came from the Carriage House Coalition's LPM, who also wrote the grant proposal that was ultimately awarded to fund the position for three years.

**Harrington**

Coalition activities included:

- Distribution of the film, "Journey into Hope: Multi-Cultural Perspectives on Domestic Violence".
- Presentation of the film at the Attorney General's Conference on Domestic Violence and Sexual Assault.
- Outreach to migrant workers, temporarily in the area to harvest the blueberry crop, primarily through the Rakers' Center (blueberries are harvested with "rakes"), which also provides medical services, general assistance, and a food pantry.
- Planning retreat with a presentation by the state Attorney General.
- Ash Wednesday rituals at local churches to commemorate those who had died during the previous year.

**Lubec**

Activities included:

- "The Shoe Project: They Came from All Walks of Life" – a visual display of shoes standing for the 15 DV murder victims in 1999.
- In partnership with the local Postmaster, creation of a domestic violence awareness cancellation. All letters posted in Lubec on October 15 were hand cancelled with the special image.
- A six week program for 9 to 12 year old girls to build self esteem and raise awareness of dating violence. Also supported with funds from the Maine Women's Fund.

### St. Croix

Activities included:

- Presentation of the Maine Silent Witness Exhibit.
- Work with the Girl Scouts of a DV Awareness patch.
- Creation and distribution of a newsletter.
- The Hairdresser Project – local hairdressers were trained to get the word out to their customers and to know how to respond when they became aware that a customer was a victim.

### Rangeley

Progress was hampered by loss of one LPM and delays in finding a successor. Activities included:

- Support for the newly hired Franklin County DV Investigator.
- Participation in a Bullying and Teasing Conference in Farmington, the county seat.
- Support for the local Walk for Violence-Free Communities.

## Year Five (2000-01)

During this period, the Project Manager increased the intensity of her oversight and support of local projects, in order to catalyze a greater effectiveness. As a result the pace of local planned accelerated substantially. She also took steps to increase the project's visibility at the state level, presenting in a number of venues and joining various coalitions and professional groups.

The greatest disappointment of the period was also the most dramatic event. A long anticipated training of clergy was under way on September 11th, when word came in of the attack on the World Trade Center. The

training was terminated in mid-career so that attendees could go home to support their congregations.

All the local coalitions committed a lot of time and effort to finishing their social marketing plans, each of which won the endorsement of the Rural Coalitions Advisory Group. Two of the LPMs, Bahia Yackzan (Harrington) and Bev Runyan (St. Croix) were honored by the First Lady at the annual Blaine House tea of the Maine Coalition to End Domestic Violence for their work to reduce domestic violence.

**Harrington**

The charter LPM left to have a baby. The new LPM had been working part time for the coalition for some months, and the transition was carefully planned and very smooth. Coalition activities included:

- "The STOP Campaign", supporting local businesses to stop IPV in their workplaces. The Chamber of Commerce was a partner in this effort.
- Targeted outreach to the gay/lesbian/bisexual/transgender community.
- Funding of the Washington County DV Initiative and hiring of the first DV Investigator.
- Valentine's Day Chocolate Fest (successful in recruiting several new coalition members)

**Lubec**

There was also a change of LPM in Lubec. Although not so carefully planned as in Harrington, the transition involved no delays, since both individuals were long-time employees of the health center. Coalition activities included:

- Distribution of social marketing materials
- A barbecue/open house
- A media presentation
- Organization of an IPV awareness concert called, *A Night of Harmony*

**St. Croix**

Coalition and LPM activities during this period included:

- Hairdresser Project Luncheon and Workshop
- A media campaign, including 50 print ads in 4 different newspapers and 966 radio spots aired during the period from July through October
- A health fair
- Support for Peaceful Choices on their October Race Against Domestic Abuse

- Assumption by the LPM of a lead role in the development of the Washington County DV Initiative.
- Organization of a county wide collaborative to strengthen Metanoia, the Batterers Intervention Project for the county

### Rangeley

After a long interim without an LPM, Kim Caldwell was hired and immediately began working to reestablish trust with old coalition partners and to build new partnerships. Coalition member participation in meetings jumped and planning was begun for a number of new programs. The coalition carried out one community education project in partnership with the Rangeley Public Library.

## Year Six (2001-02)

In the midst of this year of planning for sustainability of the local projects, the leadership changed at MPCA. Bonnie Post, the Executive Director and Principal Investigator since the inception of the IPV project, retired and was replaced by Kevin Lewis in January of 2002. At about the same time, Lynn Walkiewicz left the position of Project Manager. Jan Bondeson, the Project Evaluator, stepped in and juggled both the Manager's and the Evaluator's duties until a replacement for Dr. Walkiewicz could be found. Tom Godfrey was hired in June to manage the project through the end of the grant period.

### Harrington

Activities included:

- "Art for Peace", an exhibit of 110 pieces done by local artists, including adults, high school students, and 4th grade students – shown and five area schools and the University of Maine at Machias.
- Articles printed in the Coastal Downeast newspaper.
- Winter issue of the newsletter.
- Trainings for the Bridge Coalition, an organization of high school students raising awareness of DV among their peers.
- The Bridge Coalition brought three speakers to the high school (420 students).
- "Health Cares About Domestic Violence" Day at the health center.
- April Symposium – a celebration of the Coalition's work over the previous 5 ½ years.
- A presentation to the Washington County Leadership Institute.

- A collaboration with Coastal Ventures that place 200 informational flyers in grocery bags in local stores.
- A medical student interning at the health center produced a brochure for middle school students.

## Lubec

Activities included:

- Road signs were posted along all major thoroughfares
- Six coalition members signed up for the planned facilitators' training for the new Batterers' Intervention Program.
- A project called the Shoe Project called attention to the fact that women of all different socio-economic groups (women who wear all kinds of shoes) are victims of domestic assault. About 600 people passed through the exhibit.
- An educational drama, *Why Does She Stay?*, as presented at the Lubec Women's Club
- The special event, *Road Show for Antiques Appraisal*, raised about $1,750 for the project.
- The annual Domestic Violence Awareness Stamp Cancellation Day event
- A month-long display at the library.
- *Night of Harmony* concert
- Organized a live call-in cable TV show, "Domestic Violence in Washington County," with a potential audience of 2,500 households. The event was videotaped for rebroadcast later.
- Distributed 350 copies of the winter issue of their newsletter.
- Conducted the Community Readiness to Change Survey.

## St. Croix

Activities included:

- Tchotchkes with contact information were distributed at area hairdressers (emery boards, refrigerator magnets, pens, etc.).
- Jake & Caroline, a teen dating theatrical presentation, went the rounds of area schools.
- A media campaign ran for four months with materials in local radio and newspaper outlets.
- The coalition participated in the Sexual Assault Response Team kick-off.
- The Lending Library collection was moved to the Princeton Library.
- Much of the LPM's energy went into organizing the development of the new Batterer's Intervention Program.
- The LPM presented jointly with Keeping Kids Safe Downeast to the Calais Chamber of Commerce.
- Eight clergy participated in a specialized training.

- Formed a companion group called, "Neighbors Against Drug Abuse"
- Sponsored a "Race to End Domestic Abuse", with 80 participants
- Supported development of the Downeast Sexual Assault Response Team (SART)

**Rangeley**

Coalition activity continued to increase. Activities included:

- Provided and staffed an interactive booth at the Community Wellness Fair.
- Arranged for the Young Adult Abuse Prevention Project to perform their Jake & Caroline skit for local youth.
- Began working on a Book Project for the local school libraries.
- Presented at the Ladies Ecumenical Luncheon.
- Produced Monthly Newsletters, now up to 8 pages and a distribution of 1,300.
- Distributed 1,440 flyers and 60 posters.
- Met with the sponsoring health center's clinical staff to review screening practices.
- Arranged for three presentations of the Silent Witness silhouettes.
- Began an empowerment/support group in Stratton, one of the most remote towns in the state.
- Sponsored a Cabin Fever Festival, an addition to the annual Polar Blast Festival, which the coalition hopes to make an annual event, as well.
- Started an empowerment group for women, facilitated by a member of the coalition

## Section V

## Context

*Describe other events or situations occurring in the community or with your program (e.g., participation in other initiatives like Green Book, and other federal, state or local grants) that may have contributed or hindered efforts or outcomes of the CCR and similar processes in comparison community.*

With respect to activities external to the project itself, but focused on domestic violence policy and practice, or on the implementation of the project:

- There have been no outside sources of income other than the CDC grant and therefore no conflicting funder agendas to reconcile.
- There has been no participation in other national projects that would provide additional resources, but impose additional demands.

Two sets of changes have had an impact on local implementation, one evolutionary and the other revolutionary.

On the evolutionary side, differences in staff turnover have had a notable impact.

- On one end of the spectrum was the Carriage House Coalition in Harrington, where there were only two Local Project Managers. The second LPM had worked as a volunteer with the coalition for over a year before becoming a part time staffer, working under the direction of the original LPM, who after her departure to have a baby, continued to be involved as a member of the coalition. In this case, both principle staffers were involved with the project for practically its entire life and had a strong working relationship with each other. (It is incidental to this point, though not to the success of the coalition, that both of these individuals were skilful coalition builders who were long-time, highly respected members of the community served by their coalition.) This history correlates with the steady progress made by the coalition to overcome the challenges it met. Coalition members are candid in their praise of these two professionals and attribute a major portion of the coalition's success to their dedication and skill.
- On the other end of the spectrum was the Rangeley Project for Domestic Peace. This coalition was staffed by four different Local Project Managers, with gaps of several months in between their tenures. This lack of continuity correlates with a lack of any significant progress in gaining community involvement or response until the advent of the final incumbent, who in 18 months was able to accomplish more than her three predecessors had achieved in four and a half years. In a telling comment, an advocate from the domestic

> violence victim services provider agency serving the Rangeley area, when informed that the Rangeley project would end the bulk of its activities for want of funds to support continued staffing, said, "If you'd told me that a year ago, I'd have said, 'Fine – let it go!' Now I have to say it's a terrible loss."

In their different ways, these two examples illustrate the critical importance of professional support for volunteer coalitions if they have certain kinds of tasks to do over an extended period of time.

On the revolutionary side, the three Washington County programs were keenly affected by the closing of WomanKind, the domestic violence service agency for the county and the subsequent awarding of the state grant that had supported it to the local community action program (Washington-Hancock Community Agency – WHCA). Quite apart from the challenges involved in starting from scratch to build partnerships with a new agency in the middle of the project, this was the first time that a local DV provider program in Maine was part of a larger agency with significant non-DV responsibilities. The program, called Peaceful Choices, has had a rocky relationship with the Maine Coalition to End Domestic Violence, whose by-laws had always required that members be independent DV agencies. The resulting dispute has undermined the efforts of the Washington County coalitions to work with Peaceful Choices. They, themselves, are also in sympathy with the principle underlying the statewide coalition's membership rule, and have been severely critical of what they have seen as WHCA's failure to support DV services at a level they would have expected from a dedicated agency. The success of the different coalitions in collaborating with Peaceful Choices has varied, with the Carriage House Coalition having an easier time working with an agency in the next town, both in the southern end of the county, to the St. Croix coalition, endlessly frustrated by the failure of Peaceful Choices to provide any services at all (other than hotline availability) to people in its service area at the other end of the county, two and a half hours away.

# Section VI

# Impact

A substantial portion of the resources committed to this project were allocated to evaluation. For purposes of this draft, the findings are presented in two subsections:

1. A preliminary analysis performed by Jan Bondeson, Project Evaluator for the final three years of the project, and
2. Supplementary findings offered by Tom Godfrey, current Project Manager, and Dr. Dan Meyer, Evaluation Consultant for the entire six years.

In addition, we anticipate being able to incorporate additional analytical material in the second draft from:

3. The Random Digit Dial Survey and Network Analysis, currently being analyzed at CDC and elsewhere, and
4. Data collected and stored in house from the baseline period. We think we may be able to go beyond earlier analyses if we can recapture the raw data from this period, which has been rendered inaccessible by changes to the computer system.

Charts and graphs showing original survey data plus preliminary analyses will be provided as appendices with the hard copy version of this draft.

## Preliminary Analysis

Project impact was assessed through administration of the following instruments:

1. Anonymous Patient Surveys
2. Clinician Surveys
3. Coalition Member Surveys
4. A Network Survey
5. Chart Audits

### Anonymous Patient Survey

This survey was implemented in 2000, with a return or 823 surveys, and again in 2002, with a return of 682.

The survey was conducted in a confidential manner in the examination rooms at five health centers, four program sites and one comparison site. Women over 18 were offered the survey, and were given the opportunity to check off 11 instances of IPV, including emotional and physical abuse, in categories of "Never," "Within Last 12

Months," "Within Last 1-5 Years," and "6 or more years ago (see Appendix IIB for sample)."

In a review of the results from the individual health center sites, it was determined that the data from the control site (only on this survey) was not valid because 1) there were only 55 women who consented to fill out the survey and there was some evidence of self-selection; and 2) the pattern of responses differed widely from those at the other health centers. For instance, 100% of the 18-25 year old group reported that they had never been abused. Therefore the four program sites were compiled for this report. The economic and demographic statistics were judged to be similar in all five sites. Charts showing the findings below can be found in Appendix F:

- Most often checked in 2002 was "Yelled at or insulted you over and over (40%)" followed by "Broken or smashed things in the home when angry (33%)" and "Pushed, grabbed, or slapped you (33%)."
- Least often checked was "Used a knife or fired a gun at you (6%)" and "Threatened you with a knife or gun (10%)."

When cross-tabulated, all of the questions followed the same pattern of distribution, so using the "Yelled at" question was a good proxy for all of the questions for the first cut at the data.

The survey asked for the women's ages, in categories of 18-25, 26-35, 36-50, 51-65, and 66 and over. This was cross-tabulated with "Yelled at or insulted you over and over," and with how long ago it had occurred. It was assumed that as women got older, the number checking instances of abuse would increase. However, it was discovered that:

- The first four age groups checked off abuse between 30 and 40 percent of the time, and
- Age 66 and over actually only reported it 18% of the time. This drop in reports of abuse in that older age group was a pattern in all five health center sites.

This created an anomaly that can possibly be explained as follows:

1) Women over 65 do not perceive it as abuse,
2) They have forgotten that it occurred,
3) Their denial is more entrenched than in younger women, or
4) There is a "none of your business" effect, where they choose not to admit it.

9% of the respondents were 66 years of age or over, a little less than occurs in the population at large in Washington County (65 and older at 17%), or Franklin County (14%) so there could have been some self-selection. Cross-tabulations of age and the number responding that a provider had asked them about IPV also show that providers are not asking that age group about IPV.

Taken as a group, it was found that:

- 18-25 year olds were reporting slightly higher incidences of abuse within the last 12 months at 24%.
- 26-35 year olds were close behind at 22%.

- However, in looking at the individual health centers, there was a wide variation, with one health center reporting that 38% of the 18-25 year olds were experiencing abuse, while another health center reported 11% for that group. While all of the areas for the surveys were economically depressed, there were economic, sociological and demographic differences that might influence the discrepancies in reporting of age cohorts.

**Clinician Survey**

Clinicians were surveyed in 2000 and again in 2002[8]. Both surveys were sent to 17 clinicians at the four program sites and one comparison site, with 12 to 14 clinicians consenting. An average of the two surveys showed that:

- 60% of the clinicians said they "almost always" or "often" asked about IPV at annual exams/regular checkups, and
- 73% said they were "almost always" or "often" asked about IPV if the patient presented with an injury.

However, on the Anonymous Patient Survey only 35% of patients said they had ever been asked.

Comparing the 2000 results to the 2002 results, there were no perceptible differences in overall responses, with the exception of questions about the clinicians' referral of victims to services, offering them support and working out a safety plan. There was a slight increase in the number of clinicians reporting that they were comfortable with this.

More telling were the comments that the clinicians wrote at the end of the surveys. These are the comments from the 2002 survey:

*Has your clinical behavior regarding assessing violence issues changed in the past year or two? Why did it change?*

Comments from the four program sites:

- More aware. More likely to screen - because of IPV program
- Asking about it!
- Greater awareness - because of continued training and meetings with our IPV coalition.
- Try to ask about it more with patients - because I'm reminded of it several times a year - that this is a large issue
- I'm more conscious of the level of problems in this area - because of in-service and working with population at risk
- More aware, more assertive in asking - because of communications and this questionnaire
- Increased awareness and increased vigilance - because since moving to Maine I have seen a huge increase in number of cases.

[8] This finding will be expanded to include data from the survey conducted in 1998 [data currently not accessible].

No comment from the comparison site.

*What training and/or resources do you personally need to improve your ability to handle IPV?*

Comments from the four program sites:

- Continuous, intermittent reminders/in-services
- A special agency
- (Training on how) to ask specific questions
- Mock patients (=actresses) for us (me) to gain practice in asking pertinent questions

Comment from the comparison site:

- I have no idea what resources there are in my area to support an abuse victim.

**Coalition Member Survey**

The original Coalition Member Survey, as we explained in previous reports, was redesigned as a written survey rather than an interview. It was then divided into four surveys, renamed *Coalition Satisfaction Survey, Coalition Participant Survey, 2001 Survey of Organizations* and *2001 Survey of Intimate Partner Resources.*

The Coalition Satisfaction Survey and Coalition Participant Surveys were put together and were sent out once in 2001 and again in 2002[9]. Findings to date showed that coalition members were satisfied with the work of the coalition and their part in it and there was little difference between the two surveys. All four program sites had coalition members who represented the local direct service provider (DSP). However, a theme that ran through all four sites was complaints that the DSPs did not fully cooperate with their programs. In each case, the DSP felt that the money for the program should have come to them. At the very end, at just one site, the DSP administrator praised the progress the program had made and said she wished it could have continued.

The Coalition Member and Participant Surveys have been data entered so they can be sent to CDC.

The 2001 Survey of Organizations and 2001 Survey of Intimate Partner Resources were sent out once in three counties, two representing the program sites and one representing the comparison site. Data has been entered so that a database can be sent to CDC for analysis with the other program sites. Analysis of these two surveys has not yet taken place at the local level. Copies of these surveys can be found in Appendix IIE.

[9] This finding will be expanded to include data from the survey conducted in 1998 [data currently not accessible].

## Network Survey

This survey was performed once in 2001 in three counties. The data is currently being processed at CDC.

## Chart Audits and the Goal of Getting Clinicians to Ask Patients about IPV

Chart audits were implemented in 2000 (426 charts audited) and 2002 (393 audited). 25 charts were randomly chosen and audited for each clinician (some clinicians had less than 25 patients during the time period audited) and the audits were done onsite at the health center, looking for documentation of IPV.

The goal behind implementing the Clinician Survey and the Chart Audits was to establish a baseline in the year 2000, work with clinicians through the programs at the four health centers, and then measure again in 2002. The Anonymous Patient Survey also contained one question that asked, "Has a health center provider ever asked you about intimate partner violence?"

From 2000 to 2002 there was clear progress, going back to surveys implemented in 1998, prior to the last three-year grant. Findings are:

- In 1998 23% of women reported that they had been asked;
- In 2000 31% of women reported that they had been asked;
- In 2002 35% of women reported that they had been asked;
- The comparison health center site stayed at the 22 – 23% level, indicating a baseline.

In addition there was a distinct rise in the number of inquiries about IPV on patient charts:

- In 1998 there were 16% incidences of documentation;
- In 2000 there were 21% incidences;
- In 2002 there were 30% incidences.
- The comparison health center site actually went down over that period, from 6% to 2%.

The difference from 6% to 16% in 1998 chart audits from the program sites to the comparison site can be attributed to the previous 3-year grant. However, the program emphasis on clinician education was not as strong during that grant.

The rise can be attributed primarily to two health center sites that made the education and continuing reminder of clinicians a priority. At one site, the Local Project Manager held "We care about IPV" days at regular intervals, where the clinicians wore buttons that said they were open to questions about domestic abuse; and the LPM also regularly attended clinical staff meetings to remind them of the ongoing need to screen for IPV. At the other health center a procedure was put in place by the administrators which added a domestic violence reporting sheet to the folder when the woman came in for her annual exam. This was then kept in a confidential part of the folder after the visit.

The evaluator also discovered that any discussion about abuse often requires a number of questions from the clinician in order to elicit the information. Many times, from the way the documentation was written on the chart, it appeared that the woman was offering the information, but clinicians pointed out that it is not easy to obtain the information from an understandably reluctant patient and it usually takes more probing to get an admission.

## Supplementary Findings

Tom Godfrey, IPV Program Manager, and Dan Meyer, Evaluation Consultant, have been conducting additional analyses since the biennial progress report for the period 4/1/02 to 9/30/02. They prepared an abstract of that work for presentation at the Eighth 8th International Family Violence Research Conference in July, 2003. That presentation expands on the evaluation narrative included in the previous report. Efforts were made to draw conclusions from each source of information: anonymous patient surveys, clinician surveys, medical record audits and coalition surveys. Of particular note are the following findings:

### 1) Anonymous Patient Surveys

Anonymous patient surveys were collected during the project primarily as a means to inform clinicians about the incidence of abuse experiences in their practices. The periodic data collection process also served as a reminder to clinicians and staff of IPV activities. We did not expect to see a decrease in abuse experience over time as a direct result of coalition activities over the life of the project, since domestic violence is a multifactorial, culturally based problem that will likely take decades to change. As noted in the previous report, lifetime experience of any abuse from combined data from the four health centers was about 50%, ranging from 55% for ages 18-50, and 47% for 51-65, to 22% for 66 and over. It is unclear whether the low incidence in the oldest age group is a true reflection of these women's experiences or their memories and interpretation of the questions.

It is a matter of some interest that the lifetime experience number is so high. Most national (and international) estimates we have encountered use the number, 31%. There are several possible explanations for this discrepancy (our finding is 61% higher than the conventionally used statistic):

- Maine overall may be higher than the national average.
- Rural areas may be at the high end of the normal range (the range is not usually reported).
- Our respondents are current users of the health care system. This may increase the likelihood that they have had a recent experience of

abuse, since abuse creates psychological stress, which increases utilization of the health care system generally.

- Both our figure and the national average may be artifacts of the survey language. For instance, our survey uses behavioral language, rather than labels, asking about the respondent's experience of eleven different types of assault. For a survey to be counted in the negative column when tallying up lifetime experience of abuse, the respondent would have to respond, "Never", eleven times. We speculate that if this same instrument were used in other areas, response patterns might be similar, in which case, our understanding of the normal incidence of domestic violence would have to be adjusted.

The patient surveys also reflected an increase in clinician inquiry about violence. Overall, inquiry rates increased from 23% in 1998 to 35% in 2002. Inquiry rates at the control site remained around 23% over that period. It should be noted that the base line data are similar to those from national surveys (typically reported as showing that "80% of all women have never been asked about family violence by a health care provider"). The average increase in the target behavior (screening for IPV) at program sites was 59%. While this increase is substantial, it is clear that continued emphasis on this issue will be needed to sustain and increase these rates.

### 2) Clinician Surveys

Clinician surveys were also collected and reflect a number of changes over the course of the project. By the final project year, clinicians estimated that 29% of their female patients had experienced partner abuse at least once in their lives. While less than the actual proportion of patients reporting this experience, this still reflects an awareness that three in 10 patients they see have experienced partner abuse.

As noted in the previous report, most clinicians reported changes in their clinical behavior as a result of this project, especially increases in awareness and assertiveness in asking patients about the issue, some relating these changes directly to project educational activities. The surveys also reflect increasing awareness of local community resources, confidence in referring patients to those resources, and reduced obstacles in assisting women who have experienced abuse. We are in the process of comparing the initial clinician surveys to the final survey six years later to better quantify these changes. Changes in clinicians over the project years and the small number of clinicians (11-15) make formal comparisons difficult; trends clearly show that clinicians' intentions and behaviors changed over the project.

### 3) Medical Record Audits

Medical record audit data also showed improved performance by clinicians. As noted in the October, 2002 report, incidence of documentation of abuse inquiry increased from 16% in 1998 to 30% in 2002 at the intervention health centers and remained around 5% at the comparison site. Since the clinicians indicated that 60% of clinicians often or almost always ask about IPV at annual exams/regular checkups, an additional analysis was performed on the audit data. For those charts which contained a note from an annual exam or checkup, 45% contained evidence of an IPV inquiry; less than 5% of similar visits contained such evidence at the comparison health center. Clearly, intentions to act are reflected in this specific visit rate compared to the overall inquiry rate. Interventions with clinicians should concentrate on other types of visits where abuse issues are important and sufficient time is available to address this complex issue, such as prenatal visits and well child exams.

**4) Coalition Participant Surveys**

Coalition participant surveys also reflected important outcomes of the project. Valuable community volunteer time was dedicated to each coalition. Respondents reported an average of 5.7 coalition meetings attended by individual members during the last 12 month period and 4.7 committee meetings. In 2002, nearly all respondents could identify at least one major accomplishment of their coalition in the past year, generally related to activities carried out to increase community awareness. Nearly every respondent felt that the coalition had improved coordination of IPV services in their community.

Finally, the coalition satisfaction surveys showed that most participants felt the process of the coalitions, from encouraging open discussion to improving communication among community IPV organizations, was very positive. Across the 21 satisfaction items in that survey, in 18 items, less than 10% of all respondents across the four sites disagreed with the positively worded statements. The three exceptions were: "My abilities are effectively used by the coalition" (11% disagreed); "The coalition has a strong commitment from the policy-making level of each organization that is represented" (11% disagreed); and "The coalition has members that thoroughly represent the community" (17% disagreed). This last item reflects the difficulty some of the coalitions experienced in recruiting participants from all sectors of the community, and was also identified in the focus group results reported in October. The participants also clearly found the coalition experiences useful: only 1 of 30 participants (3%) disagreed with the statement: "The coalition has been a partnership I would like to continue."

Mr. Godfrey and Dr. Meyer will continue to refine these analyses for the final draft of this report. In particular, there is an exploration of possibly unutilized survey data from the first years of the project (1996-98) that still exist in electronic form on disk, although they cannot be found in hard copy. These records, if they exist, will take more time to find and process, since a change in the MPCA computer operating system has made access to them more problematic.

As noted above, Mr. Godfrey and Dr. Meyer will be making a presentation of the project: Godfrey T, Meyer D: "Effectiveness of a community coalition approach to address intimate partner violence in rural Maine", at the 8th International Family Violence Research Conference, Portsmouth, NH, July, 2003.

MPCA has also convened a statewide violence against women stakeholders group which intends to pursue policy changes and financial support to continue and extend the work begun during the CDC-funded IPV coalition project.

## Section VII

## Publications, Presentations, and Other Materials Produced Under the Grant

Materials generated by the four local projects and by MPCA in implementation to achieve objectives under the grant are provided in the Appendices:

- Appendix A – MPCA (previously MACC – the Maine Ambulatory Care Coalition)
- Appendix B – Carriage House Coalition (Harrington Family Health Center)
- Appendix C – Rangeley Project for Domestic Peace (Rangeley Region Health Center)
- Appendix D– Safe Harbors (Regional Medical Center at Lubec)
- Appendix E – St. Croix Advocates for Family Peace (St. Croix Regional Family Health Center)

In each appendix, the materials are organized chronologically. Materials from Years One through Three (the surveillance phase of the project) are labeled "sample", as they were in the final report for that phase of the grant. If there were additional materials created during that period, we have not been able to locate them.

### *Publications, Presentations & Materials*

| | |
|---|---|
| **Appendix A** | |
| | **Maine Primary Care Association (MPCA)** |
| | ***Previously Maine Ambulatory Care Coalition (MACC)*** |
| ***Years 1-3*** | |
| | Sample Training and Workshop Agendas |
| *7/01/98-10/31/98* | |
| | The Rural Response Newsletter |
| ***Year 4*** | |
| *4/01/00-9/30/00* | |
| | Social Marketing Training Brochure |
| | Enhancing The Effectiveness of Local Coalitions Brochure |
| *6/01/00-8/31/00* | |
| | The Rural Response Newsletter |
| ***Year 5*** | |

| | |
|---|---|
| *12/01/00-2/31/01* | The Rural Response Newsletter |
| *3/01/01-6/30/01* | The Rural Response Newsletter |
| *9/11/01* | Domestic Violence and the Religious Community |
| **Appendix B** | **Carriage House Coalition (Harrington Family Health Center)** |
| ***Years 1-3*** | Sample Materials<br>Sample Training and Workshop Agendas |
| ***Year 5*** | |
| *10/01/00-3/31/01* | Social Marketing Plan<br>Invitation to Attend A Tea For Community Members Who are Committed to Ending Domestic Violence |
| *4/01/01-9/30/01* | Stop Poster<br>LGBT Brochure |
| ***Year 6*** | |
| *10/01/01-3/31/02* | Carriage House Coalition Newsletter<br>"Night of Harmony" Article |
| *4/01/02-9/30/02* | Sample Materials<br>Carriage House Coalition Symposium<br>Art for Peace<br>Poetry for Peace |
| **Appendix C** | **Rangeley Project for Domestic Peace**<br>***(Rangeley Region Medical Center)*** |
| ***Years 1-3*** | Sample Materials<br>Sample Training and Workshop Agendas |
| ***Year 5*** | |
| *10/01/00-3/31/01* | Social Marketing Plan |
| ***Year 6*** | |
| *10/01/01-3/31/02* | Media Materials |
| *4/01/02-9/30/02* | Sample Materials |

| | |
|---|---|
| | IPV Tchotckes |
| **Appendix D** | |
| | **Safe Harbors (Regional Medical Center at Lubec)** |
| ***Years 1-3*** | |
| | Sample Materials<br>Sample Training and Workshop Agendas |
| ***Year 4*** | |
| *9/01/99-3/31/00* | |
| | Stamp Cancellation |
| ***Year 5*** | |
| *4/01/01-9/30/01* | |
| | Placemats |
| ***Year 6*** | |
| *10/01/01-3/31/02* | |
| | "Night of Harmony" Article<br>Safe Harbors Quoddy Coalition for Domestic Peace Newsletter and Materials |
| *4/01/02-9/30/02* | |
| | Sample Materials |
| | IPV Tchotckes |
| **Appendix E** | |
| | **St. Croix Advocates for Family Peace**<br>***(St. Croix Regional Family Health Center)*** |
| ***Years 1-3*** | |
| | Sample Materials |
| ***Year 4*** | |
| *9/01/99-3/31/00* | Newsletter<br>Invitation to Seminar for Hair Dressers |
| ***Year 5*** | |
| *10/01/00-3/31/01* | Social Marketing Plan<br>Invitation to Attend A Tea For Community Members Who are Committed to Ending Domestic Violence |
| *4/01/01-9/30/01* | Sample Newspaper Ads |
| ***Year 6*** | |
| *10/01/01-3/31/02* | "Night of Harmony" Article |
| | IPV Tchotckes |