

**Prevention of Family  
Violence in The Anthem  
Foundation of Ohio's  
Service Area**

**Prepared for: The Anthem Foundation of Ohio  
by The Health Foundation of Greater Cincinnati**

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# Foreword

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In 1999, The Health Foundation of Greater Cincinnati entered a partnership with the Anthem Foundation of Ohio to generate white paper reports to assess regional health care needs in four areas of concern:

- Prevention from the Harm of Health Illiteracy
- Prevention of Family Violence
- Prevention of Lead Exposure
- Preventive Oral Health Care

This report was written with the latest available data for The Anthem Foundation of Ohio's 36-county service area, shown below. The Anthem Foundation of Ohio chose Prevention of Family Violence, along with Preventive Oral Health Care, as a focused area of grantmaking for these 36 counties.



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# Prevention of Family Violence

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*“The senior boom is one of the central challenges of the coming century.”*

—President Bill Clinton, January 4, 1999

## Introduction

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Violence is one of the nation’s top sociopolitical concerns for the decade and is considered by many to be the most significant criminal justice issue. Although the deep-rooted social belief is that violence is most likely to occur from a stranger, statistics show that nearly half of all homicide victims are related to or acquainted with their assailants (Bureau of Justice, 1996). In addition, many of the partner violence cases that actually go to trial—almost half in some communities—are dismissed. The image of the family home as an idyllic, safe haven is more myth than reality for too many men, women, children, and elderly adults in our communities.

### Definitions

Because there is no single definition of “interpersonal violence” that researchers, investigators, public health officials, and others accept as universal, those studying the field must be careful not to employ or accept any one definition as prescriptive. In a special supplement of *Academic Medicine*, “interpersonal violence” was broadly defined to include

*both fatal and nonfatal violence where physical force or other means (i.e., the threat of force) is used by one person with the intent of causing harm, injury, or death to another (Alpert, Cohen, & Sege, 1997).*

From this broad classification come several subclassifications.

“Family violence,” the most common form of interpersonal violence, refers to intentional intimidation and/or physical and/or sexual violence between people who are intimately associated. Child abuse, elder abuse, and intimate partner abuse are the three primary types of family violence, with others, such as sibling abuse, being less common. Importantly, as Alpert, Cohen, & Sege (1997) point out, “the expanded nature of the family in society must also be considered when conceptualizing the term ‘family violence’” (p. S3).

Although many professionals and researchers use the term “domestic violence” to describe violence within families and intimate relationships, this term is often associated more with intimate partner violence rather than the broad range of the violence against children, the elderly, and other family members. The term is also associated more often with heterosexual partner abuse, especially given that 95% of all reported victims of intimate partner violence are women abused by male partners (Bureau of Justice, 1998). However, intimate partner violence occurs in gay and lesbian intimate relationships as well. The prevalence is unknown at this time, as national incidence rates have not yet been established.

Expanded definitions of family violence also include broad definitions such as this one:

*A systematic pattern of abusive behaviors, occurring over a period of time, that may become more frequent and severe and are done for the purpose of control, domination, and/or coercion. Such behaviors may include verbal abuse and threats; physical, psychological, and sexual abuse; and destruction of property and pets (SchorNSTein, 1997, p. 1).*

Due to the broadness of family violence, definitional distinctions must be made as the situation is discussed. One type of family violence may have specific characteristics that are not necessarily found in other types. Researchers and professionals concede that establishing definitional categories for the various forms of family violence is an on-going challenge. There simply are no standard, uniform definitions that are universally accepted. This lack of uniformity has created problems in the scientific study of family violence, mainly in the comparison of various studies to establish accurate incidence and prevalence rates. One example involves the use of “abuse” or “neglect,” which is greatly debated among professionals. What one professional considers abuse, another considers neglect. This definitional confusion makes it difficult for policymakers to create adequate social policies, especially if they are consulting research studies that use different definitions of the problem.

Fortunately, steps are being taken to standardize the definitions. In 1997, the Association of American Medical Colleges (AAMC)—with diverse contributions from the areas of medicine, public health, and sociology—published a special supplement of

*Academic Medicine* titled “Educating the Nation’s Physicians about Family Violence and Abuse.” In this supplement, the editors attempted to clearly define child maltreatment (which encompasses child abuse, child sexual abuse, and child neglect), adult intimate partner violence, and elder mistreatment:

- **Child abuse** is the inflicting, by a parent or other caretaker, of physical injury to individuals under the age of 18 through malicious, cruel, or inhumane treatment. Physical punishment that results in injuries that leave marks, break the skin or bones, or involve real or perceived threats to life or health are regarded as abusive (Alpert, Cohen, & Sege, 1997).
- **Child sexual abuse** includes the intentional exposure of individuals under the age of 18 to sexual acts and materials, the passive use of children as sexual stimuli for adults (child pornography), and actual sexual contact of children with older individuals. Children are assumed not to be able to consent to these sexual activities. A child’s apparent “consent” to participate in sexual activity does not reduce the older individual’s responsibility or alter the diagnosis of child sexual abuse (Alpert, Cohen, & Sege, 1997).
- **Child neglect** may take many forms, but the common feature is the failure of a parent or other caretaker to provide an individual under the age of 18 with basic shelter, supervision, or support. This failure can be passive, such as not obtaining needed health care, or it can be active, such as knowingly exposing a child to a hazardous situation (Alpert, Cohen, & Sege, 1997).

- **Adult intimate partner violence** is intentional violent or controlling behavior by a person who is currently, or was previously, in an intimate relationship with the victim. Abusive power dynamics predominate and define the spectrum of adult intimate partner violence. Although most victims of partner violence are women, men may also be victims of partner violence (Alpert, Cohen, & Sege, 1997).
- **Elder mistreatment** is physical, psychological, or financial abuse or neglect, and may be intentional or unintentional. Intentional mistreatment involves a conscious and deliberate attempt to inflict harm or injury, such as physical or verbal abuse. Unintentional mistreatment occurs when an inadvertent action results in harm to an elderly person (Alpert, Cohen, & Sege, 1997).

Some professionals and advocates also include self-neglect as a form of elder mistreatment. It is important that one is aware of whether self-neglect numbers are included in elder abuse statistics, as incidence and prevalence rates may vary greatly from study to study. Agencies that focus on the prevention of elder mistreatment must also decide whether to address self-neglect as a form of elder mistreatment. To do so requires special consideration to the plan an agency designs to deliver services to its target populations as well as funding strategies for those services.

### **Health Consequences of Family Violence**

The bruises and broken bones caused by family violence are only the beginning of the injuries

victims sustain. Physical and psychological injuries can cause a lifetime of harm, even after the abuse stops. Health consequences of family violence include:

- closed head injury syndrome, caused by repeated batterings;
- violentization phenomena in criminals and batterers, starting with childhood exposure to family violence;
- increase in homicides, disabling injuries, and emergency room use;
- post-traumatic stress disorder in victims and witnesses; and
- reduced educational achievement of children who are victims of or witnesses to family violence.

### **Cost of Family Violence**

Our society pays a large price for violence in its homes. Businesses lose revenue in the form of wages, sick leave, and absenteeism. Excessive school absenteeism affects a child's overall school performance and educational future and can affect the learning environment in the classroom. Bryant (1994) cited a study done by researchers at Rush-Presbyterian-St. Luke's Medical Center in Chicago that found that "the average fee for medical services for abused women, children, and older people is about \$1,600 per person per year. That translates to a national annual cost of \$857.3 million" (p.14).

The Bureau of Justice estimates that the costs associated with the physical trauma, broken or stolen property, and lost pay *for battered women alone* reaches nearly \$150 million a year. Others have estimated costs to be much higher. Dr. Richard Gelles, director of the Family Violence Research

Program at the University of Rhode Island, has estimated that annual health care costs resulting from family violence were between \$5 billion and \$10 billion annually (Seymour, 1996).

Society pays the price of family violence, particularly when uninsured individuals seek emergency medical care for family violence injuries. Rates of family violence are higher in homes earning below the poverty level, where families are less likely to have adequate, non-subsidized medical insurance (see Appendix A for poverty rates in The Anthem Foundation of Ohio's 36-county region). According to the U.S. Census Bureau (1998),

*an estimated 44.3 million people in the United States, or 16.3% of the population, were without health insurance coverage during the entire 1998 calendar year. This number was up about 1 million from the previous year.*

See Appendix B for rates of uninsurance, Medicaid, and Medicare in The Anthem Foundation of Ohio's service region.

According to the U.S. Census Bureau (1998), certain subpopulations have higher rates of uninsurance than others. Hispanics were almost three times as likely than non-Hispanic Whites to be uninsured—with uninsured rates of 35.3% compared to 11.9%, respectively. Also in 1998, 34.1% of the foreign-born population was uninsured compared to 14.4% of the native-born population, and 53.3% of poor immigrants were without health insurance (U.S. Census Bureau, 1998). Because studies have shown minority populations tend to have higher rates

of poverty and family violence, repeat visits to hospital emergency rooms by uninsured victims of family violence translate into higher costs for the medical field, insurance companies, and the public.

### **Ohio Domestic Violence Reporting Requirements**

In 1999, the Ohio State Medical Association (OSMA) created a revised edition of the comprehensive educational packet that they had created nearly a decade ago entitled *TrustTalk on Domestic Violence: Information for Ohio Physicians*. This packet is part of OSMA's family violence campaign encompassing child, elder, and intimate partner abuse. The packet teaches medical staff about the dynamics of domestic violence and suggests how to approach female patients who they suspect are being battered or emotionally abused. In addition, the packet provides clinical practice guidelines for recognizing abuse, comprehensive and updated legal considerations, a list of resources and local domestic violence shelters, and a summary of the state requirements for reporting incidents of domestic violence. These requirements are summarized here.

- The Ohio Revised Code requires medical personnel to record suspected domestic violence. Reporting domestic abuse is not mandatory in Ohio, as the state recognizes a competent adult's right to consent to report such abuse.

Medical personnel who know or have reason to believe a patient is being abused are required to record their knowledge or beliefs with their reasons for it in the

patient's medical file. Physician-patient confidentiality can not be used to exclude information regarding this report and the file may be admitted as evidence (Ohio State Medical Association [OSMA], 1999).

- Medical personnel are required to report suspected child abuse or neglect to the Children Services Board, a county department of human services that acts as the Children Services Board, or to a municipal or county peace officer. Medical personnel who do not report suspected instances can be charged with a fourth-degree misdemeanor punishable by 30 days in jail or a \$250 fine.

Medical personnel who report suspected child abuse or neglect are immune from any

civil or criminal liability that might be incurred as a result of the report. Again, physician-patient confidentiality is not grounds for excluding evidence regarding a report of a child's injuries, abuse, or neglect in a court hearing (OSMA, 1999).

- Physicians who believe an older adult (age 60 or older) is being abused, neglected, or exploited must report this belief to the county department of human services. Physicians who report suspected instances of elder abuse are immune from civil or criminal liability—except liability for perjury—unless the physician acted in bad faith or with a malicious purpose (OSMA, 1999).

## Overview of Child Abuse

Establishing accurate national incidence and prevalence rates of child abuse is difficult because of a lack of uniformity in defining the problem. In 1974, the Federal government passed the Child Abuse Prevention and Treatment Act which put forth uniform operating standards for the identification and management of child abuse cases. However, individual states continue to set their own definitions, investigative procedures, system delivery, and data collection procedures.

Surveys have shown that at least 20% of American women and 5% to 16% of American men experienced some form of sexual abuse as children. In February of 1998, Prevent Child Abuse America's National Center on Child Abuse Prevention Research began a state-by-

state survey on various issues related to child maltreatment. According to their findings:

- in 1997, an estimated 3,195,000 children were reported to state-level Child Protective Services (CPS) agencies;
- of the 3,195,000 children reported to CPS in 1997, 1,054,000—or 15 out of every 1,000 US children—were confirmed victims of child maltreatment;
- CPS agencies confirmed that 1,185 children—more than three per day—died each day in 1996 as a result of child abuse or neglect; and
- in 1997, approximately 84,320 new cases of child sexual abuse were accepted for service, accounting for 8% of all confirmed child abuse victims (Prevent Child Abuse America, 1998).

## Child Abuse in Ohio

Former Ohio Governor George Voinivich created the Governor's Task Force on the Investigation and Prosecution of Child Abuse and Child Sexual Abuse Cases in 1996 to examine a variety of issues related to the problem of child abuse and neglect throughout the state of Ohio. According to the Task Force, in 1996:

- there were 124,974 children in Ohio who were the subjects of maltreatment reports (see Appendix C for child abuse and neglect allegations in The Anthem Foundation of Ohio's service region);
- there were 20,011 substantiated cases of Ohio children suffering from some form of abuse or neglect; and
- there were 37,541 substantiated or unsubstantiated cases of abuse or neglect of Ohio children.

The Prevention Subcommittee of this task force partnered with the Ohio Children's Trust Fund to create a statewide directory of child abuse and neglect prevention programs and services. In addition, the Prevention Subcommittee conducted a needs-assessment study of additional child abuse and neglect prevention programs across the state. In September 1996, the Task Force and Ohio

Children's Trust Fund published its findings in a paper entitled *State of Ohio Needs Assessment: Child Abuse Prevention Programs*. The study identified the need for prevention programs for children, adolescents, and adults both statewide and in four regions (Northwest, Northeast, Central/Southeast, and Southwest) of the state.

Child- and adolescent-based services showed the need for similar prevention programs. Interpersonal violence prevention was at the top of each group's needs list, and support/counseling ranked second for both groups. For children, these were followed by domestic violence prevention, life skills enhancement, and mentoring programs. The next three needs of adolescents were life skills enhancement, domestic violence prevention, and mentoring programs. These rankings point to the need of prevention programs focusing on the control of interpersonal and domestic violence through support, guidance, and life skills training.

For programs listed for adults, the highest ranked priority was parenting skills training followed by home visitation, respite care, support/counseling, and domestic violence prevention. Clearly, there is a strong need for prevention programs that emphasize providing parents with the necessary support to raise their children in a nonviolent, non-abusive environment.

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## Overview of Intimate Partner Violence

While both men and women are victims of intimate partner violence, the vast majority of victims are women and the primary offenders are men: women are about six times more likely than men to experience violence

committed by an intimate partner (Bureau of Justice, 1998). (*Note: these statistics may not be adjusted for underreporting by men.*) Based on surveys and studies done by the U.S.

Department of Justice and the American Medical Association (AMA):

- on average each year from 1992 to 1996, there were more than 960,000 violent victimizations of women by current or former spouses or male partners;
- about 160,800 female victims of violence are estimated to receive services from a victim service agency each year;
- women age 16–24 experience the highest per capita rates of intimate violence;
- in 1994, women injured by intimate partners accounted for over 200,000 emergency room visits;
- about 50% of female victims report an injury of some type; about one in five injured female victims of intimate violence seek professional medical treatment;
- nearly a third of female victims of nonlethal intimate violence were victimized at least twice during the previous six months;
- 40%–60% of domestic abuse victims are abused while pregnant;
- 25% of all women who attempt to take their own lives do so because of psychological trauma caused by battering; and
- from 1976 through 1996, 30% of all female murder victims were killed by intimate partners.

Many people ask why women stay in violent relationships. Leaving an abusive and violent relationship actually puts women at greater risk for more severe abuse and even death. The victimization rate of women separated from their husbands is about three times higher than that of divorced women and about 25 times higher than that of married women (Bureau of

Justice, 1996, 1998). Isolation from support networks, families, friends, and community resources inhibits a woman's decision to leave. Many abused women are financially dependent upon their abusers and would not be able to support themselves or their children if they were to leave. They may experience feelings of shame and guilt, and many do not want to subject themselves or their families to potential public humiliation. There is also a fear that they may not be believed.

Intimate partner violence also impacts the children who witness the violence. Child abuse has been reported to occur in 33–54% of families where adult domestic violence occurs (Jaffe, 1990; OSMA, 1999). These children may experience depression, higher rates of illegal drug use, poor school performance, and delinquent behavior. Although there are no studies that find a causal relationship between exposure to intimate partner violence as children and violent behavior in their own intimate relationships as adults, exposure to such violence is believed to put children at higher risk for such behavior. Repeated exposure to violence between parents, siblings, and other family members coupled with no alternative examples of abuse-free familial relationships sends a message to a young child that violence among families and significant others is normal. Normative messages about violence in general, and the subordination of women and other minorities in particular, are so common in the general public through advertising, popular music, television, pornography, and other media, that the violence and abuse occurring in many homes

seem almost a natural extension of the larger social structure.

Intimate partner violence affects women regardless of race, class, religion, culture, sexual orientation, and socioeconomic background. There are, however, certain cultural and economic factors that put women at higher risk for intimate partner violence and create barriers to resources and services. As Pinn and Chunko (1997) point out:

*Although many of these factors apply to all abused women without regard to cultural and socioeconomic background, they hold particular power over women who may be further discouraged from seeking help because of culture, marital status, ethnic background, citizenship status, prominence within their community, or geographic isolation (p. S66).*

When planning outreach and services to women, the following factors should be considered:

- availability of a translator when a woman's first language is not English;
- traditional beliefs across many cultures that accept violence against women as a spouse's or intimate partner's prerogative;
- feelings of shame or self-blame;
- fear of further retaliatory violence if abuse is revealed;
- fear of losing a place to live if abuse is revealed;
- fear of possible consequences if identifying information is conveyed to immigration, legal, or governmental authorities;
- fear of discrimination by insurance providers; and

- fear of loss of economic support from the abusing partner.

Agencies providing services to female victims must demonstrate knowledge of and experience with the unique issues that these victims face. A service provider's ignorance of these issues may put a female victim and her children at greater risk for further violence and even death.

Intimate partner violence has received considerable national attention over the past 25 years, with significant changes in policy and reform occurring on both federal and state levels. A major federal legislative milestone came in 1994 with passage of the Violence Against Women Act (VAWA). VAWA is intended:

*To enhance the ability of States, Territories, and Native American Tribes to respond to domestic violence, stalking, and sexual assault. The legislation was designed to help communities reduce gaps in their response, with a commitment of Federal dollars and support. The VAWA creates Federal laws, expands existing programs, and establishes several grant programs (Malefyt, Little, & Walker, n.d.).*

There are also numerous national and state health associations that have developed programs and services to address intimate partner violence. As identified in Malefyt et al. (n.d.), these projects include:

- related graduate and medical school coursework,
- training and resource materials for health care providers,

- materials for victims on obtaining health care services,
- research on related health care issues,
- model protocols for response to victims,
- screening tools for violence against women,
- guidance on following mandatory reporting laws regarding violence,
- forms to facilitate proper documentation of violence against women,
- protocols for notifying advocates when a victim is identified, and
- specialized medical and multidisciplinary positions and programs to enhance medical response and coordinate interventions with

victims service programs and the criminal justice system.

In 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated that all accredited hospitals implement policies and procedures in their emergency departments and adult care facilities for identifying, treating, and referring victims of abuse. In addition, educational programs on child, elder, and intimate partner abuse and sexual assault are required for hospital staff.

## Overview of Elder Mistreatment

Of all cases of family violence, elder mistreatment is the last considered, least addressed, least studied, and least reported. Communities should consider elder mistreatment, which encompasses both elder abuse and elder neglect, and its prevention when addressing other needs of the elderly. Appendix D shows the estimated prevalence of elder abuse, based on estimated 1994 Census Bureau figures and using the national prevalence rate of 4-6%, for each of the 36 counties in The Anthem Foundation of Ohio service area (Anetzberger, 1999; Hudson, 1986; Wolf, 1999). The House Select Committee on Aging estimates that 4% of the elderly population is abused, but only one of every six cases of elder abuse ever comes to the attention of the authorities. For many professionals, the 4-6% prevalence rate is the proverbial “tip of the iceberg.” Some studies have found a prevalence rate as high as 10% of the total U.S. elderly population (Hudson, 1986).

Until recently, elder mistreatment received relatively little public attention compared to child maltreatment and intimate partner violence. This situation is changing, primarily due to the virtual explosion of the nation’s elderly population. Our country’s elderly population has grown rapidly, both in absolute numbers and in the percentage of the total population. Since 1960, the number of people age 65 and over has increased by 100%. The largest increase, however, is with the 85-and-over age group, which has increased by 274% (Administration on Aging, “Profile of Older Americans: 1998;” Hudson, 1986 ). The increase in the 85-and-over age group is of particular concern to professionals because, as studies have shown, this population has more chronic illnesses, is more frail, and has more mental health issues. These factors increase the likelihood of maltreatment because of the inherent stress and financial burden family

members face when caring for their elderly relatives.

As the “baby-boom” generation ages, population demographics challenge our society to confront the special needs and issues that affect the elderly. According to the Administration on Aging’s *Profile of Older Americans: 1998*,

*the older population will burgeon between the years 2010 and 2030 when the ‘baby boom’ generation reaches age 65. By 2030, there will be about 70 million older persons, more than twice their number in 1997. People 65+ are projected to represent 13% of the population in the year 2000 but will be 20% by 2030.*

Communities need to institute adequate plans of action to strengthen existing services for the elderly and, in some cases, create new, more comprehensive policies and services that fill the gaps in community-based service delivery systems. In addition, special consideration must be given to the development of culturally sensitive services since

*[m]inority populations are projected to represent 25% of the elderly population in 2030, up from 15% in 1997. Between 1997 and 2030, the white nonhispanic population 65+ is projected to increase by 79% compared with 238% for older minorities, including Hispanics (368%) and nonhispanic blacks (134%), nonhispanic American Indians, Eskimos, and Aleuts (159%), and nonhispanic Asians and Pacific Islanders (354%) (Administration on Aging, “Profiles of Older Americans: 1998”).*

When coordinating and designing services, service providers need to consider assessing the needs of the minority elderly in their community. Many rural Ohio counties have large populations of Appalachians and African Americans. It is advised that service providers use special outreach strategies that take into account the cultural differences and special needs of these populations (Bartos, n.d.; Briggs & Davis, 1994; Martinez; Nerenberg & Njeri).

The Administration on Aging’s “Fact Sheet” states that between 1994 and 1995, more than half (52.5%) of the older population reported having at least one disability and one-third had severe disabilities. Over 4.4 million (14%) had difficulty in carrying out activities of daily living and 6.5 million (21%) reported difficulties with instrumental activities of daily living. These activities included bathing, dressing, eating, getting around the house, preparing meals, shopping, managing money, using the telephone, doing housework, and taking medication. Considering these health statistics in relation to the approaching population explosion of our nation’s elderly population should beg the question: Who will take care of our aging population?

It is estimated that at any given time only 5% of persons 60 years or older reside in institutions (Administration on Aging, “Fact Sheet;” Hudson, 1986), implying that the majority of elderly adults live in their own homes or in the homes of relatives. Hudson (1986) points out that the

*realization has dawned that 80% of long-term care of elders is provided by family members. However, the*

*extended family is changing to a more mobile nuclear family with fewer children; and with the rising divorce rate, to a single parent family. Thus, family resources are as finite as outside material resources (p. 126).*

For the most part, our society expects families to care for their elderly relatives. Tennstedt (1994) refers to a nationwide telephone survey by the National Alliance for Caregiving (NAC) and the American Association for Retired Persons (AARP) that found that:

- the majority of caregivers are women, with 72.5% of the national sample of caregivers being female;
- spouses are the first source of caregiving assistance; offspring are usually the next source of informal care, with daughters more likely than sons to be in this role;
- friends and neighbors are mobilized in the absence of family caregivers, or as supplemental sources of assistance;
- caregiving is usually not a shared activity, as one person tends to provide the majority of informal care;
- caregivers typically live in close proximity to the care recipient, with 20% sharing a household and another 55% living less than 20 minutes from the care recipient;
- there is a higher incidence of caregiving among Asian-American (31.7%), African-American (29.4%), and Hispanic (26.8%) households than in the general population;
- caregivers in minority households were more likely than those in the general population to provide care for more than one person; and
- caregivers in minority households were more likely than white caregivers to live with the

care recipient and to have help from other persons.

Caring for elderly relatives, particularly the very old and those with severe physical and mental illnesses, can be an extremely stressful task. Children of elderly individuals may feel resentment toward their parents. Family caregivers may feel guilty about not being able to provide better care for elderly parents or overwhelmed if they also care for small children. Often, families are not prepared for the expensive care that many elderly individuals require, nor are family caregivers adequately educated or knowledgeable about aging issues. These situations prove more stressful for everyone if there is a history of tension or abuse between the elderly parent and the adult child.

The elderly relative may experience guilt and shame for being a “burden” on the family. On the other hand, some may feel that it is their families’ obligation to care for them, something their children owe them. Many elderly fear being placed (or “abandoned”) in nursing homes and make their children and close relatives promise not to “put them away.” Others cannot afford the astronomical costs of nursing home care, or even in-home nursing and assisted-living services, and therefore must rely on help from relatives.

While there are some resources and support available in most communities for the elderly and their caregivers, the services are often inadequate or are underutilized for several reasons. First, outside resources and support may simply not exist, or exist in very limited capacity, depending on the size, demographics,

and locale of the community where the elderly and their families reside. Second, resources and support may exist, but families may not be aware of their existence in the community, or may feel that they do not qualify for such services. Finally, elderly relatives and their family caregivers may know of available services but refuse to utilize such services because they are suspicious of possible intrusions of privacy and are not willing to air the family's "dirty laundry" to outsiders for fear of potential repercussions and embarrassment. Elderly persons often do not want to report abuse and neglect because the relatives they implicate "are their only source of support or because they might risk abandonment or reprisals" (National Center on Elder Abuse, 1998).

Based on a national study of domestic elder abuse reports conducted by the National Center on Elder Abuse (1998) with data collected from state adult protective service agencies and state units on aging, there has been a steady increase in the reporting of domestic elder abuse nationwide from 1986 to 1996. Among other results, the study found that:

- in 1986, there were 117,000 reports of elder abuse compared to 293,000 in 1996, representing a 150.4% increase since 1986 (it is impossible to know if these numbers represent an increase in actual cases or simply an increase in the number of reports filed);
- not including self-neglect reports, approximately 1.01 million elders became victims of various types of domestic elder abuse in 1996; the number increases to 2.16 million if self-neglect is included;

- neglect is the most common form of maltreatment in domestic settings; not including self-neglect reports, 55% of substantiated cases in 1996 involved neglect; and
- beyond neglect, physical abuse accounted for 14.6% of reports, financial/material exploitation for 12.3%, emotional abuse for 7.7%, and sexual abuse for less than 1%. Approximately 10% reported "unknown" or "other" (National Center on Elder Abuse, 1998).

Compared to child and intimate partner abuse, elder abuse is the most difficult to detect. According to the National Center on Elder Abuse (1998):

*Elder abuse is even more difficult to detect than child abuse, since the social isolation of some elderly persons may increase both the risk of maltreatment itself and the difficulty of identifying that maltreatment.*

Because it is extremely difficult to record the victims of abuse or neglect who stay in their homes or who rarely interact with others, many researchers consider national incident rates to be severely underreported and represent only the proverbial "tip of the iceberg."

Based on the recommendations set forth in the National Elder Abuse Incidence Study (1998), state and local governments and family violence service agencies should consider the following implications:

- Policy planners need to direct more attention to the abuse and neglect among people aged 85 and older, the most rapidly growing elderly age group.

- Local community organizations and corporations need to develop more appropriate service strategies (for example, mobilizing neighborhood programs and educating and sensitizing employees about elder abuse and neglect) to address the needs of the elderly, but especially for elderly persons who are unable to care for themselves or who are mentally confused or depressed because they are more vulnerable to abuse, neglect, and self-neglect.
- Given the large number of abuse and neglect incidents that are unidentified and unreported, service providers, caregivers, and all citizens who relate to elderly people need to be alerted to the problem of abuse and neglect, taught to recognize it, and encouraged to report suspected abuse.
- The education of physicians, nurses, and other health care workers—who are well-placed to detect instances of abuse as they are more likely to come in contact with the elderly—should focus on how to recognize and report signs of elder abuse, neglect, and self-neglect and where to refer victims for human and support services.
- Increased standardization of state definitions and reporting procedures for elder abuse and neglect would allow more meaningful and expedited collection and analysis of data about elder abuse, including monitoring national trends in incidence over time.

## Victim Characteristics

It is not possible, nor is it wise, to put forth one defining picture of the “typical” victim of family violence. Family violence affects every level of our society. However, studies have shown that certain sociodemographic characteristics are related to higher incidence rates of family violence (Alpert, Cohen, & Sege, 1997; Bureau of Justice, 1998; Sedlack & Broadhurst, 1996; National Center on Elder Abuse, 1998):

### Child Abuse

- Girls are sexually abused three times more often than boys.
- Boys have a greater risk of emotional neglect and of serious injury than girls.
- Although infants are also vulnerable, children are consistently vulnerable to sexual abuse after age three.
- There are no significant race differences in the incidence of maltreatment or maltreatment-related injuries.
- Children of single parents have a 77% greater risk of being harmed by physical abuse, an 87% greater risk of being harmed by physical neglect, and an 80% greater risk of suffering serious injury or harm from abuse or neglect than children living with both parents.
- Children in the largest families with annual incomes below \$15,000 are 22-25 times more likely to suffer some form of maltreatment than children from families with annual incomes above \$30,000 per year.
- Children from the lowest income families are 18 times more likely to be sexually abused, almost 56 times more likely to be

educationally neglected, and over 22 times more likely to be seriously injured from maltreatment than children from higher income families.

### **Intimate Partner Violence**

- The majority of victims are female.
- Black women experience higher rates of nonlethal intimate violence than white women.
- The highest rates of intimate violence affect women ages 16–24.
- Women living in households earning less than \$10,000 per year between 1992 and 1993 experienced higher rates of intimate violence (19.9 per thousand) than women from households earning \$50,000 or more per year (4.5 per thousand).
- Urban women experience higher rates of nonlethal intimate violence than suburban and rural women. Access to services, however, is usually much more difficult for rural and suburban victims than for urban victims because of isolation, lack of transportation, and other access issues.

### **Elder Mistreatment**

- Neglect is the most common form of elder mistreatment.
- In 1996, 66.4% of the victims were white, 18.7% were Black, 10% were Hispanic, less than 1% were Native Americans, and less than 1% were Asian Americans/Pacific Islanders.
- The majority of elder abuse victims are female.
- There is no significant difference in mistreatment by perpetrators of either gender.

- Adult children are the most frequent abusers of the elderly; other family members and spouses are ranked as the next most likely abusers of the elderly.
- In 1996, 64.2% of all reports made were substantiated; of those, 31.7% were self-neglect cases, and 25.4% were cases of abuse by others.

### **Rural Victims**

Because many of the 36 counties targeted by The Anthem Foundation of Ohio are considered rural, special consideration should be given to the unique issues and barriers that rural victims of family violence face. Isolation is a primary barrier. A victim's closest neighbor may be miles away, while the nearest family violence agency, resources, and services—including adequate health care networks—may be hours away. Lack of easily accessible public transportation increases the victims' isolation from needed services. For women who are stalked, battered, or sexually assaulted, this isolation serves as an additional tool that helps their abusers gain and maintain power and control over them, preventing them from seeking help. All rural victims of family violence—women, children, and the elderly—face similar obstacles and barriers:

- Many rural homes have no phone service and the nearest public phone or neighbor with a phone may be miles away.
- Public transportation is limited, if it exists at all.
- Police response is not immediate, and may take hours or even days, depending on the size of the police force, the distance that

- must be traveled, and road and weather conditions.
- Medical response and access to services may be hindered due to the same factors that affect law enforcement response.
  - Victims may have to travel great distances to reach a medical facility with the capacity to perform a sexual assault forensic exam (during which time evidence may be lost).
  - Resources such as sustainable jobs, child care, housing, health care, social services, and legal services may be fewer than in non-rural areas.
  - Victims' injuries may heal before they see neighbors.
  - Perpetrators have easier access to hunting weapons.
  - Women may hesitate to ask for—or judges may fail to grant—“stay away” provisions in protection orders if the jointly-owned farm is the sole source of income for the perpetrator.

- Low population density creates a likelihood that criminal justice, law enforcement, and health personnel know the perpetrator as a friend or family member.

Lack of transportation is a much more serious barrier to services for rural victims than it is for urban victims. Of the 36 counties in The Anthem Foundation of Ohio service area, half do not have public transportation systems (Stover, 1997). However, five of these 18 counties (Auglaize, Carroll, Greene, Hancock, and Mercer) are currently working to solve this problem by participating in a transportation coordination program funded by the Ohio Department of Transportation. Any community response to domestic violence in a rural setting should involve alleviating this particular barrier through coordinated efforts to transport victims to services or through the development of more in-home services and home visitor programs.

## Types of Prevention

The following definitions are adapted from the Governor's Task Force on the Investigation and Prosecution of Child Abuse and Child Sexual Abuse Cases and the Ohio Children's Trust Fund (1996). Levels of prevention include:

- Primary prevention includes activities or services offered to all members of the community, independent of risk level and focuses on promoting positive family functioning, educating the public, and influencing policy issues.
- Secondary prevention includes activities or services targeting specific populations which have been determined to be, or are assumed

to be, at greater risk of being victims or perpetrators of abuse or neglect. These programs are generally problem-focused and based on identified stressors for the at-risk population.

- Tertiary prevention includes intervention services for individuals already identified as abused or abusive.

### Types of Prevention Programs

There are a number of prevention programs that communities can implement to address the problem of family violence. Before developing a family violence prevention

program, organizations should perform a thorough community, county, or multi-county needs assessment that looks at what services are available and what services are lacking. Using this data, organizations can better plan and develop the services they will provide. Multi-agency collaborations that include health care, public safety, public service organizations, fraternal groups, congregations, post offices, etc. are very important, as each of these organizations is an important partner in the fight against family violence. Collaborations can be used to educate, coordinate, and improve the systems through which the

community provides support and accepts responsibility for its victims of family violence. And because victims of family violence are not always comfortable coming forward to admit what has happened, communities should implement special training programs for health care workers and other professionals who might come into contact with victims of family violence. All services should be culturally sensitive and accessible to individuals from all socioeconomic backgrounds.

The following table shows examples of programs currently being used in various parts of the country to address family violence:

Type of Program	Description	Type of Program	Description
Advocacy services	representatives function on a particular client's behalf and promote awareness of client needs to formal institutions such as legal and educational systems	Mentoring programs	volunteers participate in participants' lives to provide support, guidance, and friendship (e.g. Big Brothers/Big Sisters of America)
Assessment services	comprehensive, non-psychological evaluation of families and individuals in or at risk for crisis	Parenting skills training	classes for parents in areas of child development, parenting skills, and appropriate forms of discipline
Case management	one-to-one help with coordination of necessary services	Personal safety programs	educate individuals about abuse and neglect and how to recognize, prevent, and cope with precipitating factors that can lead to abuse and neglect
Crisis management services	emergency services, such as counseling or shelter arrangements, for individuals and families facing situations that may precipitate abuse or neglect	Professional training	classes for professionals, especially those mandated to report abuse, that teach them to recognize and handle potential abuse and neglect situations
Education programs	general information services that cover a broad scope of issues	Referral programs	direct individuals to needed programs and services
Home visitation programs	program staff visit the individuals or families at home and may emphasize issues such as parent education, elder care support, and parent-infant bonding	Respite care	allows caregivers who are at risk of abusing those they care for to leave family members with other caregivers until risk of abuse has passed
Interpersonal violence prevention programs	aim toward ending non-family violence (e.g. school violence, violence in the workplace, etc.)	Sex education	classes designed to teach about sexuality, safe sex, and pregnancy prevention practices
Life skills enhancement programs	strengthen coping, interpersonal communication, anger management, and conflict resolution skills; may include literacy training, job readiness training, and nutritional programs	Support or counseling programs	strengthen skills such as self-esteem, literacy, anger management, nutritional awareness, job readiness, etc
Mediation	helps peers or families settle disputes and learn conflict resolution skills	Wellness programs	promote physical health and well-being

By far, the most effective strategy to prevent family violence is a community-based approach that involves strong collaborations across a wide-range of disciplines. All social systems—including social service agencies, churches, law enforcement, the court system, health care professionals, schools, local government, and employers—need to consider family violence prevention. Agencies are encouraged to create more innovative and community-specific prevention services. Ideally, the more types of services offered in a coordinated, collaborative, and community-based response, the more likely it is that family violence prevention in the community will be successful.

### **Child Abuse Prevention**

Certain types of services have been particularly successful and nationally recognized. For child abuse prevention, Prevent Child Abuse America (1996b) recommends the following:

- **New parent support programs**, such as perinatal support programs, prepare individuals for the job of parenting. Such programs should include supports during both the prenatal and postnatal periods to ease difficulties associated with having a new infant at home. Prenatal and postnatal medical care is especially important, since low birth-weight babies, drug-exposed babies, and babies otherwise sick in infancy are at risk for being abused. Prenatal programs can build on existing medical programs and educate parents-to-be in child development, parent-child relationships, and adult relationships.

Currently, home visitation is one of the most innovative and holistic prevention

program used to educate and support the at-risk family by making a wide range of community and professional services available to the family. Services may include nurse visitation to monitor the health of an infant and mother, in-home parenting education, and intervention of a social worker to prevent the placement of an infant in foster care. Most importantly, home visitation programs strive to create social networks for new parents by connecting them with other community-based and hospital-based prevention programs. Social isolation is a proven risk factor for child abuse, and networking helps eliminate the social isolation experienced by many new parents, especially those in poverty stricken communities.

- **Parent education** started gaining support in 1989, when the family support movement pointed to an increasing need among all American families for support, advice, and role models. By targeting all families, rather than low-income or otherwise at-risk groups, parent education and family support programs have achieved the broad-based backing necessary to underwrite statewide programs.

Nationally known programs that target at-risk families—such as Parent Effectiveness Training (PET), the Parent Nurturing Program, and Systematic Training for Effective Parenting (STEP)—have various approaches toward parent education and are distinct in their use of teaching tools such as rewards and punishments, praise, and specific encouragement. Parent-focused interventions with well-specified training

components aimed at improving child rearing competence and stress management have been supported by empirical findings as effective measures for reducing risk factors associated with physical child abuse.

Groups that provide parent education, such as natural childbirth groups, community-based prevention programs, and mental health services, can also provide social support systems for families either at risk or in treatment for abuse. Mutual support and self-help groups act as a support network for family members adjusting to new roles, problems, or changes in family circumstances. These groups can help family members expand their social contacts, improve their feelings of self-esteem, and increase their knowledge of child development.

- **Early and regular child and family screening and treatment** are a continuation of the preschool screening services, such as those offered by a home visitor. The purpose of these programs is to detect problems children may be having—including abuse and neglect—and ensure that children receive the necessary physical health, mental health, and other services that will best protect them from becoming abusive parents. At the same time, these services should remain sensitive to the possibility that a child may be inappropriately labeled, which can have long-term negative consequences.
- **Life skills training for children and young adults** has two main purposes. The first is to equip children, adolescents, and young adults with interpersonal skills and

knowledge that are valuable in adulthood, especially when they become parents. The second is to provide children with skills to help them protect themselves from abuse.

Skill- and knowledge-building activities should include child development, family and life management, self-development, self-actualization, and methods of seeking help. For adolescents in particular, education in sexuality, pregnancy prevention, and issues related to parenting should be provided.

- **Crisis family support services** are also important. Lacking a support network in times of crisis puts families at significantly greater risk for abuse or neglect. To provide immediate assistance to parents in times of stress, 24-hour crisis care programs can include a telephone hotline and crisis caretakers, baby-sitters, nurseries, and counseling. Through these programs, parents facing problems can receive immediate support to alleviate the stresses of a particular situation. However, because crisis care is temporary and short-term, such programs should be equipped to refer parents to long-term services as needed.
- **Public information and education** can make the public aware of the seriousness of the problem and its implications as well as how individuals can make a difference. The effectiveness of prevention strategies can only be realized when there is a fully aware public committed to preventing child abuse and all aspects of family violence.

### **Intimate Partner Abuse Prevention**

Many family violence prevention models specifically designed to prevent intimate

partner abuse have received national recognition. Of particular interest to the medical community is the Family Violence Prevention Fund's *Best Practices: Innovative Domestic Violence Programs in Health Care Settings* (Nudelman, Durborow, Grambs, & Letellier, 1997), which highlights several programs, including the following:

- **The Hospital Crisis Intervention Project (HCIP)** is an on-site domestic violence advocacy and training program at Cook County Hospital in Chicago and is a collaborative effort of the Chicago Abused Women Coalition and the Cook County Bureau of Health Services. The staff is multicultural, offering services in seven languages. Advocates are available daily from 7:00 a.m. to 5:00 p.m. to provide crisis intervention, counseling, legal advocacy, information and support, and referrals. During the evenings, a hospital social worker is available on-call. Referrals to HCIP come from throughout the hospital, and staff work to reach out to all hospital departments. The program works most closely with the Trauma, Adult Emergency Services, Obstetrics and Gynecology, Social Work, Psychiatry, and Internal Medicine departments.

HCIP also trains health care providers within the hospital on a regular basis. All new hospital staff hear a presentation about HCIP, and other training sessions include information on the dynamics of domestic violence, appropriate questions and responses to abuse victims, and barriers to identification. The program also designed a comprehensive ten-week course on

improving the health system's response to domestic violence, which they taught to students at the University of Chicago's Pritzker School of Medicine.

- **The Medical Advocacy Project** is a collaboration between the Women's Center and Shelter of Greater Pittsburgh and Mercy Hospital, a large, inner-city teaching hospital. The project provides a full-time, on-site domestic violence advocate, numerous trainings for hospital staff, and a hospital-wide procedure manual. A Domestic Abuse Team meets monthly to discuss policy and procedures. Members include a medical advocate, Women's Center and Shelter Clinical Manager, a medical facilitator, the Emergency Department (ED) chair, an ED nurse, a second physician, the assistant to the chair of the Ob/Gyn Department, a pastoral care counselor, a Trauma Department physician, and a social worker.
- **The Domestic Violence Project** in Kenosha, Wisconsin, provides 24-hour domestic violence advocacy, referrals, follow-up contact, and on-going support to victims at two area hospitals. Specific training is provided to the general public and health care providers. Long-term individual support is available for a year or more. There are also two support groups available: one for women over 50 years of age and one for women of any age. The project also does specific outreach to minority populations. For example, they began offering support groups at a local neighborhood center where African American women felt more comfortable attending.

- **AWAKE (Advocacy for Women and Kids in Emergencies)** was formed to broaden child abuse programming to include intervention on behalf of battered women and to unite services offered separately to women and children. The program receives input from a multidisciplinary team made up of Child Protection Services, District Attorney, Department of Social Services, and other outside agencies. In the program, battered women with abused children are paired with a family violence advocate. The advocate helps the woman create a safety plan which is then updated during each subsequent contact and is designed specifically to keep the mother and her children together and safe. There are also two bilingual/bicultural advocates to provide culturally-specific outreach and services at a health center located in a public housing development. Special emphasis is placed on services to pregnant women because, as the program discovered, 40% of pre- and postnatal patients indicated that they were being battered.

### **Elder Abuse Prevention**

For elder abuse prevention, the following best practices and model programming are suggested.

- **Public awareness and professional training** can raise “the nation’s consciousness about the nature of elder mistreatment, the potential situations that may place older individuals at risk, and the means of obtaining help for older persons is at the core of a successful prevention program,” according to Wolf (n.d.).
- **Public awareness** includes media activities, conferences, and production and dissemination of informational materials. Professional trainings are also particularly important. As Wolf (n.d.) points out, “the General Accounting Office found that public awareness and professional training were considered to be more effective in case identification than mandatory reporting laws.” It is important to train hospital staff, social workers, and other professionals who come into contact with the elderly on the dynamics of abuse and the necessary steps to take to report and/or deal with suspected abuse. Examples of professional training include the development of training manuals and curricula on family violence/elder abuse, regular in-service meetings on different topics and issues associated with elder abuse, and the development of graduate level courses on adult protective services in schools of social work.
- **Coalition building** is important because, as Wolf (n.d.) states, “greater cooperation among the members of the local human service system lessens the chances that vulnerable persons will fall between the cracks. It creates opportunities to identify community resources, offers more options for handling cases, expands knowledge and skills of participating professionals, improves chances of obtaining likelihood of acquiring voluntary and in-kind support; and assists in policy development.”
- **Mental health services** should be a very high priority for elder abuse prevention programs. According to Wolf (n.d.), “Research in elder abuse has shown that mental illness is found

more often in abuse families than non-abuse ones.” Options for preventative strategies involving mental health services for older adults include:

1. monitoring of discharged mental hospital patients who live with elderly parents;
2. encouraging health care personnel and service workers in the aging field to take a more active role in convincing a family to seek mental health services and to aid them in the process;
3. improving accessibility, availability, and utilization of community mental health services by establishing strong linkages between the aging network, adult protective services, and the mental health systems as well as creating more specialized programs for serving the mental health needs of older persons; and
4. training the elderly and their caregivers in at-risk environments about aging and the aging process, problem solving, stress and anger management, available services, and utilization of community resources can decrease symptoms of distress, as Anetzberger (1999) has also emphasized.

- **Family caregiver services** are often omitted, although numerous sources emphasize (Wolf, n.d.; Wolf & Pillermer, 1989; Administration on Aging; Edinberg, 1986; Filinson & Ingman, 1989; Hudson, 1986; National Center on Elder Abuse, 1998; Quinn & Tomita, 1986; Tennstedt, 1999) that elder abuse prevention strategies should include attention to caregivers of older persons who have chronic and debilitating diseases. The elderly with severe mental health issues, such as Alzheimer’s disease, are particularly at risk for abuse. Conversely, Alzheimer’s patients may also perpetrate abuse against the family caregiver.

Respite and day care services can provide some relief to family caregivers, much like respite programs for parents or family members caring for infants and children. As mentioned earlier, caregiver education on the aging and the aging process is very important. Support groups may provide an emotional support system that lessens the sense of isolation and overwhelming responsibility that many caregivers feel.

## Evaluation

In the not-so-distant past, evaluation of nonprofit programs meant reporting the number of individuals served, their basic demographic information, and, possibly, a laundry list of services and activities provided to clients and the broader community. Several recent key events have seriously and radically impacted the nonprofit world, namely: welfare reform, the rise of managed health care, and the overall decentralization of the

government’s role as a social service provider to its citizens. These events have affected the accountability of non-profits in that “head-counting” and “laundry-listing” are no longer acceptable evaluation measures. The issue of welfare reform is a good example. In the frenzied rush to remove people from the welfare rolls, federal and local governments have turned to non-profits and, in some cases, for-profit entities to take welfare-dependent

individuals and transform them into self-sufficient heads-of-household in as little as four weeks. Programs are expected to accomplish this task in spite of the fact that many of these clients face multiple barriers such as drug-dependency, family violence, mental disability, lack of education, lack of job skills, and lack of affordable quality childcare.

The increased demand for performance-based outcomes means funders want to see measurable changes in client attitudes and behaviors. Unfortunately, funders have imposed performance outcomes on programs without providing additional funding support for the staff time, training, and computer technology necessary to track and report clients' performance outcomes. Most non-profits would agree that comprehensive evaluation of their programs and services is both necessary and desired, both from a funding perspective and from a quality-service perspective. Non-profits want to know that they are having a positive impact on their clients and the community, but they need to find creative ways to evaluate their

programs without taking resources away from their clients.

Outcome evaluation should help answer the question, "Does this program make a difference?" This question is more easily answered when applied to intervention rather than prevention programs. As Repucci, Britner, and Woolard (1997) point out, "It is difficult to measure true prevention because if something is prevented successfully, then 'nothing happens'" (p. 45). Unfortunately, the definition of successful prevention is what makes funding prevention programs unappealing to many funders. Family violence funders, for example, will look for reduced incidence rates of child, elder, and intimate partner abuse as the only measure of a family violence prevention program's success. Organizations developing family violence prevention projects need to show funders that, even though the projects have "nothing happens" outcomes rather than tangible ones, they are valuable in helping potential abusers and protecting potential victims.

## Conclusion

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Family violence is a complex social issue, one that requires more study and research. This fact does not mean that efforts to prevent family violence should be halted. Quite the contrary, given what we know about family violence—such as risk factors, victim barriers to services, gaps in local service delivery areas, etc.—and what we know about the changes occurring with American family structures and population demographics, the need for family violence prevention services is clear. The

growing elderly population in particular will pose significant challenges to our communities' service delivery systems. Communities should design prevention strategies appropriate to its unique populations, characteristics, and needs when working to prevent family violence. For example, programs in rural areas should focus on providing services that eliminate barriers and reduce social isolation (such as transportation serves, home visitor programs, mobile health care units, etc.)

Society ultimately bears the costs of family violence, the majority of which are not economic. Individual and community health and productivity suffer, causing consequences that affect all levels and areas of society.

Prevention of all forms of family violence is essential to eliminating the problem. The challenge lies in developing community-based, collaborative approaches to bring about widespread, sustainable change.

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## Appendix A

**Percentages of persons in the 36 counties of The Anthem Foundation of Ohio service region living below 100 and 200% of the Federal Poverty Level.**

County	% of Persons <100% of Poverty Level	% of Persons <200% of Poverty Level
Adams	28.5%	54.1%
Allen	12.7%	32.1%
Auglaize	6.3%	23.0%
Belmont	17.4%	39.3%
Brown	14.2%	36.7%
Butler	10.6%	24.9%
Carroll	11.7%	35.5%
Clark	13.4%	31.4%
Clermont	8.7%	24.0%
Clinton	12.3%	31.4%
Columbiana	15.9%	38.7%
Darke	9.0%	29.7%
Greene	9.5%	23.1%
Hamilton	13.3%	28.5%
Hancock	7.3%	22.7%
Hardin	16.4%	36.7%
Harrison	19.7%	46.1%
Highland	16.5%	42.2%
Holmes	17.2%	47.6%
Jefferson	17.1%	36.1%
Mahoning	15.9%	35.1%
Mercer	6.7%	26.6%
Miami	8.4%	23.9%
Monroe	21.5%	45.4%
Montgomery	12.6%	28.0%
Noble	16.4%	43.9%
Preble	10.2%	30.4%
Putnam	5.8%	22.3%
Scioto	25.8%	50.3%
Shelby	7.7%	26.0%
Stark	11.1%	29.0%
Trumbull	11.4%	29.0%
Tuscarawas	11.2%	34.5%
Van Wert	7.1%	24.3%
Warren	6.4%	19.6%
Washington	13.7%	34.3%

## Appendix B

**Percentages of uninsured, Medicaid, and Medicare populations in the 36 counties of The Anthem Foundation of Ohio service region.**

<b>County</b>	<b>% of Population Uninsured</b>	<b>% of Medicaid Enrollees</b>	<b>% of Medicare Enrollees</b>
Adams	12.2%	18.5%	16.8%
Allen	12.1%	10.3%	15.6%
Auglaize	7.7%	4.2%	16.1%
Belmont	15.2%	12.8%	20.8%
Brown	10.4%	10.3%	13.2%
Butler	14.6%	7.0%	11.9%
Carroll	8.8%	9.6%	11.2%
Clark	11.3%	11.6%	16.2%
Clermont	18.1%	6.8%	8.7%
Clinton	10.7%	8.2%	14.7%
Columbiana	10.9%	11.0%	17.3%
Darke	9.6%	5.3%	15.4%
Greene	16.1%	5.9%	9.5%
Hamilton	12.1%	10.8%	15.4%
Hancock	8.2%	5.2%	13.6%
Hardin	8.6%	8.2%	14.9%
Harrison	2.9%	13.7%	20.1%
Highland	8.2%	10.0%	16.4%
Holmes	5.3%	3.1%	7.8%
Jefferson	13.7%	13.7%	20.9%
Mahoning	16.1%	13.9%	20.2%
Mercer	9.7%	3.7%	15.3%
Miami	8.2%	6.0%	14.6%
Monroe	0.0%	12.7%	17.3%
Montgomery	11.0%	10.1%	15.6%
Noble	8.0%	12.2%	13.9%
Preble	11.8%	6.1%	13.6%
Putnam	8.1%	5.0%	13.7%
Scioto	14.2%	20.0%	18.1%
Shelby	3.1%	5.9%	12.5%
Stark	11.5%	9.3%	17.4%
Trumbull	8.1%	10.6%	16.4%
Tuscarawas	12.6%	7.9%	16.9%
Van Wert	6.7%	4.2%	14.9%
Warren	15.0%	4.5%	10.0%
Washington	14.2%	9.4%	16.4%

## Appendix C

### Child abuse and neglect allegations in the 36 counties of The Anthem Foundation of Ohio service region.

County	Child Abuse/Neglect Allegations 1998	Total County Population (1990 Census)
Adams	615	25,371
Allen	1,838	109,755
Auglaize	324	44,585
Belmont	525	71,074
Brown	282	34,966
Butler	2,814	291,479
Carroll	336	26,521
Clark	583	147,548
Clermont	2,166	150,187
Clinton	860	35,415
Columbiana	4,435	108,276
Darke	289	53,619
Greene	935	136,731
Hamilton	11,232	866,228
Hancock	519	65,536
Hardin	312	31,111
Harrison	171	16,085
Highland	357	35,728
Holmes	122	32,849
Jefferson	192	80,298
Mahoning	1,612	264,806
Mercer	254	39,443
Miami	434	39,754
Monroe	98	15,497
Montgomery	4,748	573,809
Noble	203	11,336
Preble	365	40,113
Putnam	91	33,819
Scioto	998	80,327
Shelby	427	44,915
Stark	4,074	367,585
Trumbull	201	227,813
Tuscarawas	778	84,090
Van Wert	183	30,464
Warren	342	113,909
Washington	653	62,254

## Appendix D

### Elder populations and estimates of elder abuse in the 36 counties of The Anthem Foundation of Ohio service region.

County	Estimated 1994 Total Population	Actual Number of Persons Age 65 & Over	Estimated Rate per 1,000*
Adams	27,201	3,827	122
Allen	109,234	15,214	487
Auglaize	46,622	6,586	211
Belmont	70,571	13,783	441
Brown	38,270	5,137	164
Butler	312,835	33,228	1063
Carroll	27,849	3,978	127
Clark	147,856	21,261	680
Clermont	164,012	14,846	475
Clinton	37,666	5,135	164
Columbiana	111,406	17,183	550
Darke	54,141	8,328	266
Greene	139,906	14,090	451
Hamilton	867,728	120,357	3851
Hancock	67,683	9,171	293
Hardin	31,436	4,460	143
Harrison	15,988	2,887	92
Highland	38,479	6,034	193
Holmes	35,069	3,984	127
Jefferson	78,737	14,012	448
Mahoning	263,885	46,444	1486
Mercer	40,470	5,708	183
Miami	96,475	12,628	404
Monroe	15,293	2,475	79
Montgomery	572,140	74,503	2384
Noble	11,793	1,843	59
Preble	41,526	5,320	170
Putnam	34,806	4,478	143
Scioto	81,858	12,670	405
Shelby	46,679	5,662	181
Stark	374,612	56,065	1794
Trumbull	228,829	34,103	1091
Tuscarawas	86,512	13,451	430
Van Wert	30,265	4,721	151
Warren	126,657	11,886	380
Washington	63,550	9,027	289

\* Based on national prevalence rate of 32 cases per 1,000.