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Developing a Domestic Violence Protocol for Marriage Education: Critical Components and Cautions

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It is important for professionals involved in marriage education initiatives to address domestic violence. One way to do this is to create and use a violence protocol. This article discusses why this is important and reviews lessons learned from the development of a protocol in one federally funded marriage education initiative. Recommended components for violence protocols are reviewed, including mechanisms to encourage safety in disclosure and referral, sensitivity to culture, and understanding the scope and impact of domestic violence. The importance of collaboration with and adaptation to each community is discussed, and suggestions for educators, clinicians, and researchers are provided.

KEYWORDS domestic violence, marriage education, violence protocol

Marriage education is a "movement" that is gaining momentum, with programs proliferating across the country (Brotherson & Duncan, 2004).

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Research suggests that these types of programs can help improve relationship health and stability (Butler & Wampler, 1999, Hawkins, Blanchard, Baldwin, & Fawcett, 2008; Larson, 2004). Moreover, scholars assert that having a healthy marriage is associated with many positive outcomes for individuals, children, and communities (Amato, 2004; Waite & Gallagher, 2000; Wilcox et al., 2006). Yet, marriage education or enrichment programs are not free from controversy. One area of concern is the claim that these programs may endanger partners or discourage victims of violence from leaving abusive relationships. Some argue that using federal funds to support marriage education initiatives is inappropriate and "places domestic violence (DV) victims at increased risk" (Leiwant, 2003, p. 1).

Marriage scholars counter that existing initiatives have not increased rates of DV (e.g., Pardue & Rector, 2004), and that one of the characteristics of a healthy marriage is that it is free from violence or coercion (Moore et al., 2004). Also, most proponents of healthy marriage initiatives are supportive of individuals leaving violent relationships (Roberts, 2006).

Unfortunately, the debate around the key issue of safety can result in polarization that limits constructive dialogue. While it is important to acknowledge that some values of healthy marriage proponents and DV professionals may diverge, individuals from each perspective likely have similar beliefs concerning safety and well-being of individuals. These values can be starting points for collaboration in decreasing violence. Certainly one area of agreement between the various parties is the desire to reduce both the frequency and the intensity of violence in intimate partnerships (Roberts, 2006). Bringing together DV professionals with marriage educators to establish protocols to assess and act against violence is one logical and opportune way to address this problem.

PURPOSE OF ARTICLE

The purpose of this article is to discuss the development of a DV protocol for use within a community healthy marriage initiative (CHMI). First, we will review the scope of the violence problem and how this relates to CHMIs. We will also offer preliminary data from our initiative that underscores the need for a protocol. Second, we will discuss the process of developing a DV protocol. Third, we will review the key components that should be in a protocol. Fourth, we present relevant lessons for researchers and practitioners.

VIOLENCE AND RELATIONSHIP INTERVENTION

Violence is a significant national and international problem with numerous social costs, yet it often remains undetected by professionals who could intervene (Barnett, Miller-Perrin, & Perrin, 2005; Garcia-Monroe, Jansen, Ells-

berg, Heise, & Watts, 2006). Intimate partner violence comprised 20% of violence crimes against women in 2001 (Rennison, 2003), and the incidence of physical abuse by an intimate partner is approximately 25% (NCIPC, 2002). With regard to intervention, Stith and McCollum (2007) argue that work with couples will always include work with violence. In their DV-focused couples treatment, as few as 6% of couples report violence or abuse as the presenting problem, and yet a more thorough assessment suggests that violence is present in over half of the couples who come for couples therapy (Stith & McCollum, 2007).

Not only is violence prevalent, it is multifaceted, multicausal, and complex. There are many types and patterns of violence in intimate relationships, with varying degrees of intensity and risk. For example, one influential typology distinguishes between situational couple violence and intimate terrorism (Johnson & Ferraro, 2000). Situational couple violence is the most common form of DV and tends to occur when an angry argument escalates into verbal and physical aggression (Johnson & Leone, 2005). This type of violence is common in community and agency samples, is not characterized by domination and control, and is less likely to result in serious injury. In contrast, intimate terrorism describes a pattern that is often associated with traditional "battering," where a male is psychologically and physically abusive and controlling toward his female partner (Johnson & Leone, 2005). This form of violence is more dangerous and more likely to result in serious injury to women. Unfortunately, research suggests that this type of severe violence is also a common problem in virtually all cultures and countries (Garcia-Monroe et al., 2006).

Because intimate partner violence is prevalent, helping professionals, including relationship educators, should be prepared to screen for and understand dynamics of abuse and violence. Still, many feel unprepared to address violence, or are unsure of what steps to take if it is identified. This is not surprising, since there are many challenges in assessing violence and abuse including (a) reluctance of victims and perpetrators to be forthcoming; (b) denial and minimization; (c) the tendency to focus on other presenting problem areas (e.g., "communication problems") and thus miss violence; and (d) insufficient training of professionals for assessment of abuse indicators (Goldner, 1999; Henning, Jones, & Holdford, 2005; Jory, 2004; Whiting, 2008). Additionally, many forms of traditional couples work can exacerbate abusive dynamics by implying that it is the responsibility of the couple, rather than the perpetrator, to fix. Couples work can invite victims to believe they can fix their partners if they try harder (Bograd, 1999). Those who are working in CHMIs need to be aware of abuse dynamics and be prepared to take appropriate safety steps when abuse is identified. This may include referral to DV treatment programs for offenders, support groups for victims, or therapy.

The Bluegrass Healthy Marriage Initiative

Federally funded CHMIs are required to create a DV protocol to address issues of safety. One of these initiatives is the Bluegrass Healthy Marriage Initiative (BHMI). BHMI (also referred to herein as the "Initiative") is a collaboration between the University of Kentucky Department of Family Studies and Bluegrass Healthy Marriages Partnership (BHMP), a Lexington, Kentucky-based nonprofit organization. The Initiative serves a coalition of partner organizations from various sectors of the community–business, education, government, healthcare, faith-based, and others. BHMI seeks to support healthy marriages and co-parenting relationships through research, marriage/relationship education programming, and public awareness activities. Whereas many other coalition-based, healthy marriage projects in the country use a standard curriculum and approach, BHMI operates in a decentralized model. This means that the community organizations that join have control over the education programs they implement. While BHMI works with a select group of programs and providers, Initiative staff do not directly provide services. Rather, marriage and family therapists, family life educators, and other trained staff from nonprofit partners are contracted to provide programs from a list of approved curricula.

Findings from Our Sample

BHMI conducts research to assess relationship and demographic information for its community partners. Individuals who are planning on participating in marriage education programs offered through these partners complete a preprogram assessment battery. This helps Initiative staff identify constituent needs and select appropriate education programs as well as screen for violence potential. The screening is done using the Intimate Justice Scale (IJS), which is an instrument that assesses the ethical dynamics of a relationship, including fairness, control, psychological abuse, and physical violence (Jory, 2004). We chose this scale because of its brevity, as well as its global focus on equality, fairness, and care in a relationship. We were interested in the motivation and impact of individuals' choices, rather than only knowing specific acts of aggression, (e.g., Conflict Tactics Scales; Straus, 1979).

In the IJS, participants are asked to rate their partner on fifteen statements related to their perceptions of their partner's attitudes and actions. They check a Likert scale ranging from strongly disagree (1) to strongly agree (5). For example, "I am often forced to sacrifice my own needs to meet my partner's needs," "My partner retaliates when I disagree with him or her," and "Sometimes my partner physically hurts me." The IJS has been shown to predict risk for psychological and physical abuse. The 15 IJS items are

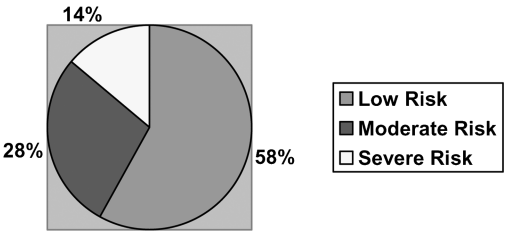

FIGURE 1 Risk for Violence Potential in a Marriage Education Seeking Sample.

summed and scores range from 15 to 75, with higher numbers indicative of more severe control and violence potential. There are two cutoff scores, one for moderate violence potential (30) and another for more serious violence and control potential (45). There are no subscales.

Jory's (2004) data on the IJS indicated the 15 items loaded best onto a single factor. We conducted principle components factor analyses using a single factor, separating men's and women's responses. Factor loadings on the 15 IJS items for men (N = 252) ranged from 0.56 ("physically hurts me") to 0.84 ("forces me to do things"); the reliability of this scale was good (α = .94). Factor loadings on the 15 IJS items for women (N = 381) ranged from 0.57 ("physically hurts me") to 0.85 ("resents being questioned"); the reliability of this scale was also good (α = .95). Jory's data also indicated good validity for the IJS. The total IJS scored was significantly correlated with the Conflict Tactics Scale (Husband-Wife version; Straus, 1979) $r = 0.77$, $p < .001$ (violence scale), $r = 0.51$, $p < .001$ (verbal aggression), and also with relationship adjustment, measured by the Dyadic Adjustment Scale (Spanier, 1979), $r = -0.89$, $p < .001$. Among our participants, a very modest test of validity yielded results in the predicted directions: the IJS was significantly correlated with relationship adjustment, measured by the Revised Dyadic Adjustment Scale, $r = -0.74$, $p < .001$, and with psychological distress, $r = 0.42$, $p < .001$.

To date, 575 individuals have completed the IJS. Results suggest that there are many in our sample of education-seeking individuals who are at risk for, or who are dealing with control or violence. As shown in Figure 1, our nonrandom, community-based sample scored 58% in the low-risk (below 31) category (n = 333), 28% in the moderate-risk (from 31 to 45) category (n = 161), and 14% in the severe-risk category (n = 81). As we increased the number of participants in our initiative over time these percentages remained roughly the same, suggesting that these risk levels were similar among samples from various participant organizations.

Although these cutoff scores offer useful categories, there were several individual items that were of interest. For instance, in response to the statement, "My partner retaliates when I disagree with him or her," 13.5% (n = 78) of respondents checked "agree" or "strongly agree." Likewise, in response to: "My partner believes he or she has the right to force me to do things,"

10% (n = 58) of respondents agreed or strongly agreed. These items demonstrate how a relationship can be characterized by control or abuse, without necessarily being violent. In response to the item "sometimes my partner physically hurts me," 2.4% (n = 13) of individuals checked either "agree" or "strongly agree." Responses to these items do not conclusively indicate violence, but individual items and cutoff scores are useful in identifying potential patterns of risk related to controlling or abusive relationship dynamics (Jory, 2004).

PROCESS OF PROTOCOL DEVELOPMENT

As we moved from grant proposal to implementation, our protocol evolved in an iterative fashion with the input of many. Those involved included the grant investigators and personnel, federal consultants, and legal and other community professionals. Throughout the process the guiding concerns focused on ensuring: (a) there would be safe opportunities for participants to disclose violence; (b) participation in any program would be voluntary and informed; and (c) personnel involved would be prepared to detect DV and to deal with issues that surfaced. This section will focus on the process of protocol development, with an emphasis on how this may apply to similar projects.

Early Stages

Our efforts began during proposal drafting, at which time initial community contacts took place. We had existing relationships with some local professionals, including an attorney who was already involved in both local DV prevention and the Bluegrass Healthy Marriage Partnership. We worked with others at the university and on staff who knew local reporting procedures (e.g., spouse abuse is reportable by law in Kentucky) and we were aware of local resources and personnel. As the project was launched and staff joined, we furthered these community relationships and worked to familiarize ourselves with other local efforts. For example, we contacted and worked with the local women's shelters and community DV prevention board.

We began with a "blueprint" of potential protocol components that we received from The Lewin Group, which is a consulting firm that works with health care and human services organizations, including some CHMIs. This consultation was facilitated in part by our federal funder. We will discuss this further when we review the protocol components. Some of these tools that we used have since been further developed and put on the National Healthy Marriage Resource Center website: http://healthymarriageinfo.org. Our guiding concerns and safety questions needed to be adapted for the initiative's specific goals and the community's resources.

A lot of time was spent early on developing relationships between the Initiative staff who were creating the protocol and the community DV parties.

The violence prevention advocacy attorney was an important entry figure in this regard, introducing us to several violence prevention professionals in our area. It was important that we were very open with these professionals about our commitment to appropriate identification and referral. Also, we were direct about our initiative structure and goals, and we talked about the limitations our organization would have in identifying and referring for violence. This candor helped our credibility among some who were initially skeptical of our motives.

The involved parties had a series of meetings and conference calls to critique and refine the emerging protocol. BHMI staff facilitated these meetings, involving Initiative personnel, invested community individuals, university and legal experts, an executive director of a local DV program, federal consultants, grant administrators, state advisors from the Cabinet for Health and Family Services, and the president of a local DV prevention board. This process took many months, and produced many areas of consensus. There were also questions that took time to resolve.

One concern arose from our decentralized model of program delivery. There was fear regarding how adequately trained each of the providers would be in DV procedures, regardless of whether they had the protocol. For example, some questioned whether being trained to use the protocol would ensure that a marriage education leader would be aware and confident enough to pursue warning signs and help someone follow the steps to accessing needed services. These concerns were addressed and resolved to varying degrees, which will be discussed further in the protocol components section.

Another challenge related to maintaining confidentiality during research procedures. We wanted participants to complete their assessment packet without fear that their partner might see how they were rating their relationship, particularly if there were control or abuse issues. We decided to have partners sit on opposite sides of the room from each other during this time. Sending our proposal through the university Institutional Review Board was another monitoring step that was useful here.

We also reviewed all of the common marriage education curricula that would potentially be used by our partners. Each program was ranked with regard to sensitivity to safety issues, and these rankings were shared with community partners to help them make more educated choices about relationship education programs. To address potential gaps in trainer knowledge about DV, we coordinated with some of the community personnel to learn of training that was happening locally or regionally that we could recommend to the Initiative partners. We discussed various procedures for handling crisis situations and reviewed and included all local laws pertaining to reporting of violence. For example, in Kentucky, reporting adult violence is mandatory. Therefore, we needed to have a plan for Initiative partners that helped to

guide them through the steps of what to ask about and watch for, but also how to report (or help participants report) abuse.

Although not every concern was resolved to every participant's satisfaction, the collaborative process seemed to elicit genuine commitment from those who participated in the construction of the protocol. The few lingering concerns were primarily regarding the decentralized model and how the individual trainers would use the protocol. However, the protocol itself contained all the components that each participant had suggested. With the protocol in place, it was expected that control and violence would be more likely detected and appropriate referrals made.

THE PROTOCOL COMPONENTS

The final document, entitled: *Responding to Domestic Violence Issues in the Bluegrass Healthy Marriage Initiative*, is available on the BHMI website at: www.ca.uky.edu/healthymarriage or by contacting BHMI at 859-257-5527. The protocol contains many of the original components suggested by the federal consultants as well as other components that developed through the interaction with the various participants. There were twelve main components in the protocol, some of which were more extensive than others. There were also some appendices that provided further resources. Each of these sections will be discussed briefly.

One—Introduction and Core Partners

This section lists the title of the protocol as well as those who are core partners in the Initiative.

Two—Purpose/Mission/Principles of the Program

This section reviews the purpose and guiding principles of BHMI. These include healthy relationship support, publication and amassing of resources, and raising awareness. This section reaffirms the commitment to safe and healthy relationships. For example, principle one states "Healthy marriages are based on free choice; BHMI is not interested in forcing marriage on anyone and does not support trapping individuals in abusive relationships."

Three—Scope and Purpose of Protocol

This consists of a review of the complexity and challenge of DV, and a statement on the purpose of the protocol, namely: "that domestic violence issues within families targeted by BHMI are safely, routinely, and consistently identified and appropriately addressed and that adequate supports and safeguards are in place for families dealing with domestic violence."

Four—Shared Principles, Shared Concerns

There is a review in this section of the commitment to safety, nonbias toward single parents, and sensitivity to diversity in relationships and culture (this is also expanded in an appendix and in component Ten).

Five—Definition of Violence

One of the challenges in the professional world of studying and responding to violence is that there is little consensus on what it is. Definitions can focus on patterns of violence (e.g., Johnson & Leone, 2005), types of perpetrators (e.g., Holtzworth-Munroe & Stuart, 1994) or whether it is marital violence or violence between other intimate partners (e.g., DV vs. intimate partner violence). In this protocol we used a standard definition of abuse that is found on the National Domestic Violence Hotline: "Abuse is physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone" (www.ndvh.org).

Six—Prevalence of Domestic Violence

Here we review some national statistics on the rates of IPV, and then compare those to state and local rates. We list the county prevalence indicators for the areas served by the Initiative. We mention statewide efforts to reduce DV, and we then discuss how our initiative may be facilitative in addressing these goals. We also list relevant agencies that serve our service area.

Seven—Raising Awareness among Partners

The goal of this section is to articulate specific roles that partner liaisons have in service delivery oversight. For example, expectations are given for each partner coordinator to be trained in the use of the protocol, in the chosen curricula, and in DV awareness training.

Eight—Providing Safe Opportunities to Disclose: Self-Screening for DV

This is one of the most important components of the protocol as it addresses some of the limitations of the de-centralized model of the initiative. To help partners consistently screen for DV among their constituents who come to education programs, the protocol specifies several things. First, that all promotional materials use a prepared script that helps individuals understand that relationship education classes are not appropriate for relationships characterized by abuse. Several indicators are written into this script ("does your partner ever . . .?") that help to identify abuse dynamics. Second, prior to

each class, copies of safety planning are placed in women's restrooms, and community resource pamphlets are handed out in classroom areas. Third, before or during the first education/activity class takes place, all potential participants view a 10-minute video/DVD entitled *Smart and Safe: Marriage Education and Domestic Violence Awareness*.

This video was created professionally in collaboration with those involved in our DV protocol process and has been adopted by other initiatives since its creation. The video provides an introduction to what relationship education consists of, discusses how other resources are more appropriate for abusive relationships, and it defines DV and safety planning. This video is available through BHMI through the contact information listed above. After the video is shown, each participant is handed brochures including a list of local numbers and a National Domestic Violence Hotline tri-fold (in Spanish on one side, and English on the other). This pamphlet has a screening set of questions to help identify abuse dynamics. A script introducing the video and the brochures is put in the protocol that is to be used by the service provider as another way to ensure consistency across programs. For example, the script includes the following:

> You might be wondering why we're bringing up the issue of Domestic Violence in a marriage education class. Unfortunately, a recent study showed that as many as 35% of Kentucky women will experience some form of domestic violence in their lifetime. So while you may not have ever faced it, you very well may know someone who is living with domestic violence ... I'm passing out some information we want everyone in class to have ... [the facilitator then reviews local resources, hotlines, and information]. If the video or the reading materials have sparked a question or concern for you, you are welcome to talk to me either during a break tonight, or some other time.

Nine—Providing Safe Opportunities to Disclose: Interacting and Responding

This section of the protocol is structured to help coordinators first, provide an environment that is safe for abuse disclosure, and second, know what to do if disclosure occurs. This section also refers to educational material in an appendix on why disclosure is difficult for many victims, and how a professional can encourage and support disclosure. If indicators of abuse are found, the protocol provides scripts and prompts that can be used to appropriately and confidentially inquire of individuals who may be at risk. Also, each coordinator receives from us a descriptive statistical report of their particular group's mean risk levels. Even if individuals do not choose to disclose, the coordinator will be aware of the levels of risk among their participants.

The next steps in this section review what to do when abuse is disclosed. These steps include assessing immediate danger (and calling police if necessary), providing local therapy and shelter referral, and discussing the steps of mandatory reporting (state laws are provided in the appendix of the protocol).

Ten—Cultural Sensitivity

This section reaffirms that effective service delivery includes understanding the needs and culture of those being served. Accordingly, it reminds protocol users of the importance of appreciating differences in ethnicity, literacy/educational attainment, religion, and socioeconomic status. There is an appendix in the protocol specifically reviewing how these may be relevant for the service area. For example, the appendix covers breakdown of ethnicity, religion, and socioeconomic status rates for the provider area, and offers some suggestions on being culturally sensitive regarding assessment and discussion of DV.

Eleven—Confidentiality

There is a discussion here about the importance of confidentiality and sensitivity when working with couples. Also, there is a reminder of how confidentiality can affect the safety of victims, as well as a review of legal and ethical obligations of confidentiality. (For more information regarding confidentiality and informed consent in family life education programs, see NCFR's *Ethical Guidelines for Family Scientists* at www.ncfr.org/gov/ethicguide.asp.)

Twelve—Review and Refinement of Protocol

This section states a policy that the protocol will be reviewed by BHMI and local DV professionals on a regular basis (every 6 months) to review strengths and weaknesses and to make adjustments where needed.

DISCUSSION

Creating and using this violence protocol has reaffirmed to us that this is an important process. Our interactions with other professionals, our review of existing scholarship, and our own research findings all support the notion that DV is prevalent and costly, and that it is a crucial topic for marriage educators to understand and be prepared for. Of particular note is the finding that among those in our community sample, 28% were at moderate risk for DV and 14% were at severe risk as measured by the IJS. This finding in

this nonclinical sample is all the more sobering in light of previous research indicating that IPV is typically higher among clinical samples (Johnson & Leone, 2005). Although only item 15 of the IJS measures violence directly, the rate of 42% of the sample being at a partial level of risk for various types of control and abuse underscores the need for prevention and intervention generally, and for a functional DV protocol specifically for CHMIs. We will review some of the most relevant lessons learned by offering implications for clinicians/educators and researchers.

Clinical and Educational Implications

When healthy marriage initiatives are pursued, there are several things that professionals can do to prepare for violence issues. If initiative personnel are not specifically trained in violence (including clinicians), it is highly recommended that they pursue such training. At minimum, they should familiarize themselves with issues related to disclosure, referral, and local resources. When professionals educate themselves about violence, they are less likely to be recruited into the denial that is often associated with violence in relationships (Ehrensaft & Vivian, 1999). The good news is that awareness of violence among professionals may be increasing (Dersch, Harris, & Rappleyea, 2006), and violence may be less common and less accepted in marriage than it was 20 years ago (Amato, Booth, Johnson & Rogers, 2007). Nevertheless, disclosure and reporting is often very difficult for victims of violence, and professionals can unintentionally contribute to this difficulty by ignoring relevant signs or appearing judgmental (Barnett et al., 2006; Feldman, Whiting, & Ho, 2007). Well prepared interventionists will assess and refer to the type of help that is most appropriate for the type of abuse (Greene & Bogo, 2002; Stith et al., 2006; Stith, Rosen, McCollum, & Thompsen, 2004).

Since there are many relationship initiative configurations, there needs to be many types of violence protocols. The discussed protocol could be adapted for use in a variety of settings, including agency, community, faith-based, or educational settings. Regardless of type, issues of safety–including voluntary participation, safe assessment, disclosure, and referral–should be foremost in guiding the development of such a protocol. Also, regardless of initiative model, effective collaboration is a key to bringing together appropriate content into a useable and effective protocol.

Particularly in the case of a university-community partnership, it is important to appreciate the various values and goals driving the parties who are involved (Carlton, Whiting, Bradford, Dyk, & Vail, 2009). Whether between university researchers and faith-based or nonprofit leaders, or between DV awareness, prevention, and intervention experts and marriage and relationship educators, differing values and goals require a foundation of relational goodwill and trust. These differences also require vivid clarity in the way partnerships and activities of the initiative will operate (Carlton et al., 2008).

As discussed above, in our case this took openness, time, and a willingness to learn from everyone who was invested. Our experience was that those most invested in this project were those associated with marriage education, and those with more caution were the individuals associated with the women's shelters. Working together on a protocol was our way of finding common ground despite the varying goals each party had regarding the role of local relationship initiatives (Roberts, 2006).

It is possible that marriage education initiatives, when implemented with an effective awareness of violence, can be another forum to help educate, prevent, and address violence. The individuals involved in the administering of the initiatives can learn more about DV as they create protocols and weave violence awareness into the curriculum. This may raise awareness among participants, some of whom may need help but are reluctant to see themselves as abused or abusive (Henning et al., 2005).

Research Implications

Although this article is not a research report, it does provide content that raises empirical questions. For example, at this point there is little rigorous scholarship to shed light on the question of whether marriage education may increase or decrease violence potential. Also, it would be interesting to know from users of a protocol how helpful they found it to be, and how it was used to help individuals receive services for violence. It may be that some areas of the protocol will be more useful than others, or that there are components that should be added. Process research of CHMIs could help shed light on these questions.

Since research on violence prevalence among those presenting for relationship education programs is scant, the data from our initiative offer an initial glimpse into these percentages. Among our sample there existed many who were at risk for or who had experienced violence, supporting the need for careful assessment and referral procedures in marriage education programs. Although we do not know typical percentages of violence among those seeking relationship programs, it is likely that there will always be some who are experiencing violence among those served by CHMIs. Not only is violence common, but some individuals dealing with control or violence may see these programs as a resource. Many who are victimized are not looking for a way out of the relationship, but for a way to have a better (e.g., free of violence and control) relationship (Stith & McCollum, 2006).

CAUTIONS AND CONCLUSION

There are limitations to applying our protocol and process to other initiatives. For example, much of our energy toward keeping consistency in our

decentralized model would not be as critical in a standardized service delivery program, where the same programs are delivered by the same people. It may be that there are other components or processes that would be helpful to have in protocols for other types of initiatives. While we have suggested that violence awareness and advocacy could occur through relationship education programs, clearly these programs are not sufficient in dealing with the complexities of assessing and referring for violence. As discussed, they are not intended to treat violence. However, it may be that increasing relationship skills and awareness can help individuals avoid problematic relationships, although this link of reducing aggression through prevention is one that needs further research (Pardue & Rector, 2004). There is much yet to be learned about the impact of CHMIs on individuals and relationships, but it is likely that these programs will continue to occur. Those who offer these types of programs are obligated to do all they can to ensure the safety of those who attend.

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