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Using Community Perspectives to Address Sexual and Domestic Violence: Results of a Mixed Methods Formative Evaluation

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Abstract

Purpose: Sexual and Domestic Violence (SDV) has escalated since the pandemic, highlighting the need to address the multi-faceted issue through community-based approaches. Understanding the community context is foundational to addressing gaps in unmet needs, improving collaboration, and increasing awareness surrounding SDV issues. This study addresses SDV in child and adult survivors in a small, under-resourced town in Massachusetts through a mixed-methods formative evaluation, conducted in collaboration between an academic institution and a local health department. **Methods:** The formative evaluation employed a mixed-methods approach guided by the Consolidated Framework for Implementation Research (CFIR). The CFIR explored internal context, individual traits, intervention design, external factors, and processes related to SDV including: 1) identifying engaged and unengaged entities regarding domestic violence (DV); 2) conducting stakeholder surveys (n=7) and interviews (n=8) with community organizations, schools, health agencies, public safety, and mental health clinicians; 3) analyzing qualitative and quantitative data on stakeholders' readiness, motivations, and influence to impact SDV; and, 3) recommending areas for intervention and further collaboration aligned with the CFIR domains. **Results:** Most respondents acknowledged SDV as a community issue (n=5, 71.4%) with unmet needs (n=5, 71.4%). Some perceived barriers to accessing SDV support included a lack of awareness among community members about existing resources (n=4, 57.1%) and a stigma that prevents access to these resources (n=6, 85.7%). Qualitative insights highlighted challenges such as mental health and substance use complicating SDV intervention barriers such as insufficient emergency housing and staffing, a lack of resources for addressing crises, a call for more preventative efforts for youth, and considerations for improving data communication. **Conclusion:** The findings led to actionable recommendations to enhance existing programs and create new initiatives, fostering a coordinated system to address SDV. By employing a mixed-methods approach, the study offers a nuanced understanding of local challenges and opportunities for implementation, informed by the diverse perspectives of community stakeholders. The involvement of community voice ensures that local efforts are targeted and appropriate, resulting in more effective and inclusive systems-level approaches to SDV. Findings highlighted the need for post-COVID strategies that target SDV awareness and prevention, address stigma and access, improve resource allocation, and support robust multi-sector collaboration.

Introduction

Sexual and Domestic Violence (SDV) is a persistent public health issue in the United States, with an estimated 10 million people affected each year [1]. Defined by the CDC as the perpetuation of physical, emotional, and sexual abuse, SDV falls into a range of types, including child and adolescent abuse, elderly abuse, and intimate partner violence. Within a community, SDV leads to increased healthcare costs, decreased productivity, and the perpetuation of generational trauma [2]. The prevalence of SDV disproportionately affects certain sociodemographic groups. For instance, 43.7% of non-Hispanic Black women report experiencing SDV compared to 34.6% of non-Hispanic white women [3]. Individuals from lower socioeconomic backgrounds are also more likely to encounter SDV [4]. Youth exposed to physical violence are also at a higher risk of engaging in or becoming victims of dating aggression [1]. SDV is influenced by various factors at community and system levels, including average income, residential stability, social norms, and resource availability [1].

SDV has been at the forefront of public health initiatives for some, but the urgency to address it has become more pressing in recent years. During the pandemic, there was an 8.1% increase in SDV cases nationwide [5], posing challenges for healthcare systems due to uncertainties and control measures [6] given the context. Staffing shortages, underreporting, and access barriers further compounded the problem [7].

Although the increase in SDV wasn't uniform across U.S. cities [8], factors such as increased substance use and economic hardships contributed to the rise in SDV, especially among adolescents and young adults [9]. The rise in mental health issues and substance use disorders during the pandemic has worsened the challenges survivors face in accessing resources [10]. Societal stigma and misconceptions create barriers, as survivors fear their experiences may be dismissed [11]. Stigma, along with societal norms and limited awareness of resources, further discourages help-seeking [11,12]. Addressing the escalating rates of SDV requires community-

based interventions and multi-sector engagement to counter these barriers from the pandemic's lasting impact.

Collaboration among educators, law enforcement, and public health agencies is essential for addressing gaps in unmet needs, improving communication, and raising awareness of SDV resources [13,14]. Multi-sectoral initiatives that consider the community context effectively provide comprehensive, community-tailored, and sustainable SDV programs [15]. Therefore, engaging the community is essential to understanding the context, resources available, and barriers to change.

A mixed-method evaluation of the SDV landscape captures community voices and stakeholder perspectives, informing tailored interventions and fostering cross-disciplinary collaboration, particularly from factors exacerbated by the pandemic. While quantitative data highlights trends, the data is often underreported, inaccurate, and lacks community context [16]. Thus, qualitative assessment is essential to identify gaps in addressing SDV response [16].

This study aims to uncover the themes and understandings of SDV gaps in a small Massachusetts community post-COVID-19 and other trauma-related events experienced by the community. This mixed-methods formative evaluation was conducted through an established collaboration between an academic institution serving as an independent evaluator for the local health department (LHD). The LHD serves the coastal community of approximately 18,600 people, which, despite its proximity to a large metropolitan city, lacks resources.

The town's close-knit, multi-generational community fosters social cohesion but reinforces stigma around issues such as SDV. With 33.9% of women and 31.7% of men in Massachusetts reporting intimate partner violence or stalking [17], it is suspected there is an underreporting of SDV, highlighting the need for targeted strategies.

Methods

This mixed-methods formative evaluation explores barriers, capacity, and perceptions of addressing SDV as a social issue within a community context. Particularly, given the impact of COVID-19 on SDV, the evaluation identifies areas of improvement, opportunities for collaboration, and technical needs. While this study focuses on addressing SDV, the process of the mixed-methods formative evaluation in a community context applies to all prevalent public health issues [18].

Conceptual framework

This study includes both quantitative and qualitative data collection but focuses heavily on the latter due to the exploratory nature of investigating stakeholder perspectives. Quantitative findings informed focus areas for further exploration during qualitative data collection, which follows similar protocol used in the field to assess stakeholder and decision-maker perspectives to better tailor local health programming [18].

Mixed-methods formative evaluation, data collection, analysis, and results were organized based on the Consolidated Framework for Implementation Research (CFIR), a framework used to explain the barriers and facilitators to addressing SDV in a community context [19]. The CFIR is used to identify barriers and facilitators to guide implementation strategies, and its flexibility lends itself to program adaptations [19]. The CFIR allowed findings from this study to be organized into actionable recommendations that account for the range of existing programs and efforts within the community, identified the available resources and gaps, and perceptions from various stakeholder perspectives [19].

This study was designed and conducted before updates to the CFIR [20], and as such this study is organized by the original five domains of the CFIR: characteristics of the intervention, outer setting, inner setting, characteristics of the individuals, and process [19]. These domains represent the complex contexts that impact the implementation of programs.

Study Design

The formative evaluation included a stakeholder power and interest analysis with the local public health director to determine a discrete number of stakeholders to engage in interviews. A survey was administered before interviews, guided by the CFIR domains, to understand participant attitudes about SDV, roles within the community, decision-making authority, knowledge of the issue, and perspectives on addressing SDV in their community. The survey findings were used to develop the semi-structured interview questions, also organized by the CFIR, and further serve as probes to access more information from stakeholders. The study was reviewed and determined exempted by the University Institutional Review Board (IRB # H-44120).

Recruitment

Stakeholder analysis

A stakeholder analysis was conducted to determine the individuals most pertinent to SDV issues and resources within the community. With the collaboration of the local public health director, stakeholders identified included individuals and organizations associated with activities and services related to domestic violence, with the power to influence programs and/or policies or both [21]. Each was then assessed for their level of power to influence SDV efforts and interest to address SDV on a five-point Likert scale (1= very low, 2= low, 3= average, 4= high, 5= very high). The interest of each stakeholder was assessed by the level of investment in SDV efforts, while their power was assessed by their ability to impact these efforts, whether they supported efforts or hindered progress in the area. Additional factors were assessed for each stakeholder, including the stage of change of readiness to address the issue, the level of commitment to engage resources and supports, and engagement strategies such as planning and collaboration [21]. Stakeholders were classified into stages of change, based on the Transtheoretical Model, according to their motivation and level of planning to act against SDV [22]. This model describes how individuals change their behavior, identifying distinctive stages to promote action steps [22]. Additionally, the LHD director provided context regarding the

identified stakeholders' individual needs, benefits, and areas of resistance.

A composite score was calculated, based on the interest and power scores, for each stakeholder to categorize them into quadrants of high power/high interest (n=4); low power/high interest (n=5); high power/low interest (n=4); and low power/low interest (n=2). Priority was given to interviewing stakeholders in the high power/high-interest category and the high power/low-interest category (73%, n=11) with equal representation from the other two quadrants to generate findings that could lead to actionable recommendations for change within the community. Consideration of stage of change and stakeholders' needs, benefits, and challenges informed the final list of priority stakeholders to interview (n=11) and the interview questions and probes.

Study Sample

Recruitment of identified stakeholders began with an email introduction by LHD director, followed by the evaluation team providing project details and participation guidelines. Participants were invited to complete an anonymous survey and then schedule an interview. Upon confirmation of the interview, a second email was sent to arrange the hour-long interview. One additional follow-up email was sent to participants who did not respond initially (n=5).

Eleven stakeholders from public and private agencies were contacted. Those contacted included stakeholders directly involved in SDV issues and resources including law enforcement officers, housing specialists, youth adjustment counselors, peer counselors, and community program staff. Of the eleven contacted for stakeholder interviews, eight agreed and were available (72.3%). Over half of the stakeholders who received the survey (n=11) completed it (n=7, 63.6%). Although the sample size is small, it captures various perspectives on SDV within the community and introduces a replicable approach to community-engaged research for assessing viewpoints and informing practice.

Data collection

Surveys

The 15-minute online survey, distributed in July 2023, addressed respondent characteristics, perspectives on SDV, current actions regarding SDV, and interest in future initiatives. Survey data informed the semi-structured interview guides, providing baseline context, stakeholder perspectives, knowledge, engagement, and identifying gaps and needs regarding SDV.

Interviews

Semi-structured interviews with stakeholders were scheduled during August and September 2023. Each interview was one hour and conducted on Zoom. The purpose of the interviews was to explore survey themes in more depth and other constructs of the CFIR that were difficult to examine quantitatively. The interviews, structured around the CFIR domains and constructs, used open-ended questions focused on three key areas: resource accessibility, responsiveness to needs, and advantage of programs/perceptions of other partners in the community.

Analysis

A descriptive quantitative analysis of anonymous stakeholder responses (n=7) was conducted using Qualtrics© software in September of 2023 (Qualtrics, Provo, UT, USA). The analysis covered categorical and continuous data with the use of the SAS© software version 3.81 (SAS Institute Inc., Cary, NC, USA) to summarize stakeholder characteristics and response frequencies, aiding in trend identification and assessing community needs regarding SDV.

Quantitative analysis was performed on all stakeholder interviews (n=8). Interviews were semi-structured and included comments and responses made by stakeholders, providing a more narrative approach to interviewing. Qualitative interviews were analyzed through NVivio 13 (2020, R1) and coded according to the CFIR. The team analyzed the interview notes and transcripts jointly, with two or more members present during NVIVO coding. During coding, team members discussed different views and interpretations of interview findings into the most appropriate CFIR construct, of which disagreements were discussed until resolved through consensus and, when necessary, a third team member.

Results

Quantitative Survey Findings

Surveyed agency stakeholders (n=7) represented public health, public safety, housing authority, and public schools. Most held leadership roles (57.1%, n=4), or held roles in community health, (28.6%, n=2), behavioral health (42.9%, n=3), environmental health (14.3%, n=1), health education (14.3%, n=1), preparedness (57.1%, n=4), business operations (28.6%, n=2), office administration (28.6%, n=2), information systems (28.6%, n=2), public information (42.9%, n=3), enforcement (42.7%, n=3), and advocacy (57.1%, n=4). Three respondents had worked with their agency for five years or fewer (42.9%, n=3), two for six to ten years (28.5%, n=2), and two for more than ten years (28.5%, n=2). Agencies were funded through federal funding passed through by the state (57.1%, n=4), local resources (57.1%, n=4), state sources that exclude a federal pass-through (42.9%, n=3), and private foundations or grants (14.3%, n=1) with one (14.3%) unsure of funding sources.

Respondents reported the current state of SDV in the community as steady (60%, n=3), with one respondent reporting experiencing surges, then periods of calm, and one respondent indicating 'unknown'. However, one-third of respondents (33.3%, n=2) reported an increase in demand for resources related to SDV since COVID-19. More than half (57.1%, n =4) agreed that colleagues at their agency supported community members in accessing resources for SDV with the remaining unsure of existing resources (42.9%, n=3). In addition, most respondents strongly agreed (80%, n=4) that their agency believed their agency helped survivors access resources, and somewhat agreed (80%, n=4) that their agency collaborates with other community agencies to address SDV. In contrast Among respondents, 60% (n=3) disagreed that their

agency provides adequate SDV support or referrals, while 60% (n=3) felt more could be done. Additionally, 20% (n=1) reported no well-defined protocols, 20% (n=1) a vague plan, and 20% (n=1) outdated protocols for addressing SDV.

As shown in Table 1, respondents strongly agreed (28.6%, n=2), somewhat agreed (42.7%, n=3), or were neutral (28.6%, n=2) that SDV is a problem in the community (Table 1). A majority of respondents (71.43%, n=5) either strongly or somewhat agreed that community leadership is equipped to respond to the community needs (Table 1). Furthermore, respondents either strongly agreed (14.3%, n=1), somewhat agreed (42.7%, n=3), were neutral (28.3, n=2), or somewhat disagreed (14.3%, n=1) that responding to SDV requires more resources than are currently allocated (Table 1).

Most respondents (71.4%, n=5) were neutral about the pandemic's impact on responding to SDV. However, 57.1% (n=4) either strongly or somewhat agreed that the pandemic increased SDV (Table 1). Most respondents strongly agreed or somewhat agreed (57.1%, n=4) that there are unmet needs related to SDV among community members, with 28.6% (n=2) of respondents neutral (Table 1).

Indicate your level of agreement:	**Strongly Agree N (%)**	**Somewhat Agree N (%)**	**Neutral N (%)**	**Somewhat Disagree N (%)**	**Strongly Disagree N (%)**
I think sexual and domestic violence is a problem in Winthrop.	2 (28.57%)	3 (42.86%)	2 (28.57%)	0 (0.00%)	0 (0.00%)
I feel the current leadership in Winthrop and/or surrounding communities is equipped to respond to the needs of Winthrop community members.	2 (28.57%)	3 (42.86%)	1 (14.29%)	1 (14.29%)	0 (0.00%)
Responding to sexual and domestic violence requires more resources than are currently allocated.	1 (14.29%)	3 (42.86%)	2 (28.57%)	1 (14.29%)	0 (0.00%)
Responding to sexual and domestic violence has become more difficult since the COVID-19 pandemic.	1 (14.29%)	0 (0.00%)	5 (71.43%)	0 (0.00%)	1 (14.29%)
There are community spaces in Winthrop for community members experiencing sexual and domestic violence.	1 (14.29%)	1 (14.29%)	3 (42.86%)	2 (28.57%)	0 (0.00%)
There are resources in Winthrop for community members experiencing sexual and domestic violence.	2 (28.57%)	3 (42.86%)	1 (14.29%)	1 (14.29%)	0 (0.00%)
I think there are unmet needs related to sexual and domestic violence among *community members* in Winthrop.	0 (0.00%)	5 (71.43%)	2 (28.57%)	0 (0.00%)	0 (0.00%)
I think there are unmet needs related to sexual and domestic violence among *youth* in Winthrop.	1 (14.29%)	3 (42.86%)	2 (28.57%)	1 (14.29%)	0 (0.00%)
I believe the COVID-19 pandemic has increased sexual and domestic violence and its impacts among community members.	2 (28.57%)	2 (28.57%)	2 (28.57%)	0 (0.00%)	1 (14.29%)
I believe that community members in Winthrop are experiencing increased levels of anxiety and depression as a result of sexual and domestic violence.	2 (28.57%)	1 (14.29%)	3 (42.86%)	0 (0.00%)	1 (14.29%)
I believe that YOUTH in Winthrop are experiencing increased levels of anxiety and depression as a result of sexual and domestic violence.	1 (14.29%)	2 (28.57%)	3 (42.86%)	0 (0.00%)	1 (14.29%)
I feel connected and engaged with community members in the Winthrop community.	2 (28.57%)	4 (57.14%)	0 (0.00%)	1 (14.29%)	0 (0.00%)

Table 1: Stakeholder perceptions and attitudes towards SDV in the community.

Stakeholders identified perceived barriers to accessing SDV resources, with four reporting they don't know what resources exist (57.1%) and six reporting a stigma attached to accessing resources (85.7%). Other reasons included a lack of available resources (14.7%, n=1), a lack of an in-town hospital/urgent care (14.7%, n=1), and fear and shame as barriers (28.6%, n=2). Additionally, respondents reported mixed perspectives on the extent to which their agency promotes education and awareness of SDV, with 40% (n=2) agreeing, 40% (n=2) disagreeing, and one neutral (20%). Two respondents strongly or somewhat agreed (40%) that their agency engages with historically marginalized groups to reduce barriers to accessing resources, two respondents disagreed (40%, n=2), and one was neutral (20%, n=1). Three

respondents (60%, n=3) strongly or somewhat agreed that their agency prioritizes cultural humility and belonging in addressing SDV, with two being neutral (40%, n=2). All respondents indicated agreement (40%, n=2) or neutrality (60%, n=3) in their agency facing barriers that ultimately impact its efforts to address SDV.

Most respondents (80%, n=4) have partial decision-making power in SDV programming. They identified key areas for improvement, including mental health resource connections (57.1%, n=4), actively addressing SDV (57.1%, n=4), building community trust (42.9%, n=3), capacity building (28.6%, n=2), enhancing agency networks (28.6%, n=2), strengthening community ties (42.9%, n=3), increasing funding (28.6%, n=2), and streamlining data systems (14.3%, n=1). Only one respondent (14.3%) saw no benefit in increased SDV focus. The majority of respondents are very likely to seek out collaboration with other community organizations (80%, n=4) and surrounding communities (80%, n=4) to support their agency's SDV response. Furthermore, products and/or resources respondents would find helpful to their agency in supporting the community in responding to SDV included an increased social media presence (42.9%, n=3), investments in mental health services (71.4%, n=5) website (28.6%, n=2), newsletter (14.3%, n=1), training for professionals (57.1%, n=4), increased investment in community programming (57.1%, n=4), tool kit (42.9%, n=3), manual (14.3%, n=1), report with qualitative information (14.3%, n=1), success stories (14.3%, n=1), information graphics (14.3%, n=1), and other (14.3%, n=1), including support groups and responder training. Some factors that motivate respondents to support a community response to SDV included enhanced networks/collaborations (40%, n=2), helping community members (60%, n=3), and social responsibility (40%, n=2).

Qualitative Interview Findings

Results from the interviews were organized by each of the five CFIR domains (intervention characteristics, outer setting, inner setting, characteristics of individuals, and process) and their constructs (i.e. implementation climate, patient needs and resources, planning, other personal attributes, and adaptability). Figure 1 presents the density of response for each construct across all interviews, with the size of the box indicating the frequency at which the construct was addressed during an interview. Exemplar quotes for each construct and domain provide more qualitative detail about the frequency of the construct (Table 2).

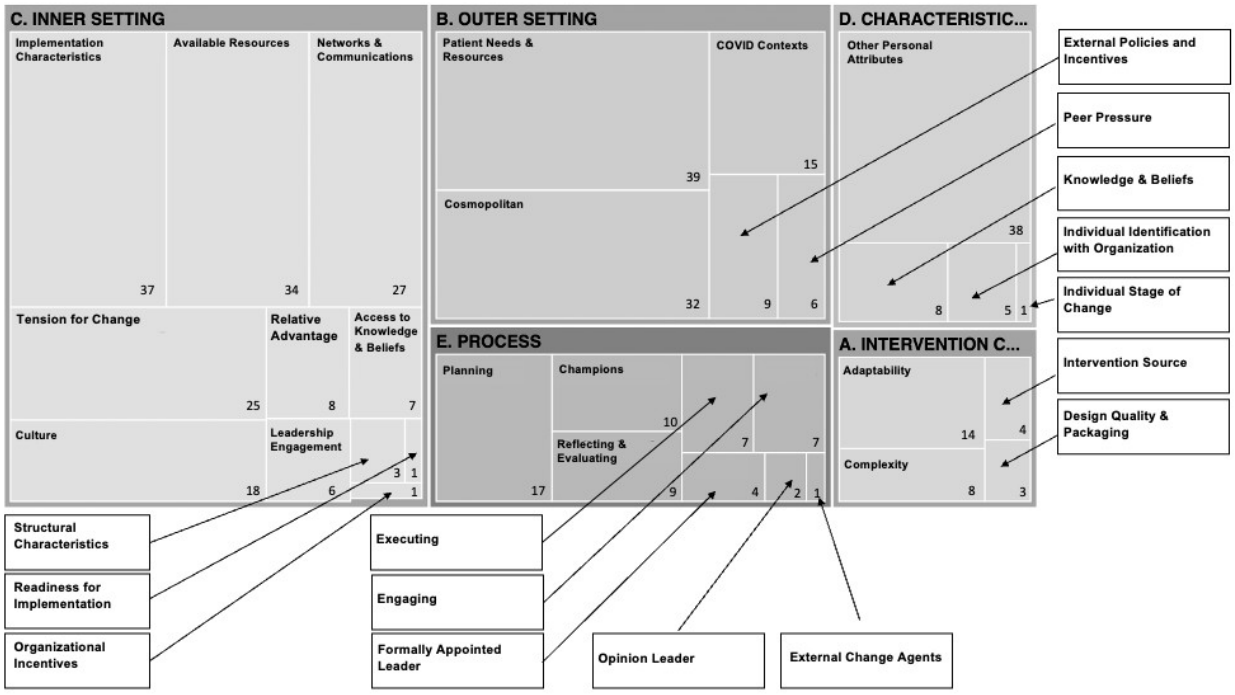

Figure 1: Coding densities of interview findings for respondents (n=8) on needs related to sexual and domestic violence, organized by CFIR constructs.

Domain 1: Intervention Characteristics

This domain addresses factors that impact the implementation of programs, including costs and design quality & packaging as well as the perceptions of organizations and individuals on the efficacy of implementation [19]. Within the intervention characteristics domain, the adaptability construct had the highest density of responses, with stakeholders reporting a need to adapt to the changing mental health climate among youth; to combine mental health and SDV supports for adults; and, to enhance collaboration and protocols across various health sectors. Within the complexity construct, stakeholders often reported a major overlap of SDV with mental health and substance use, with one stakeholder reporting, "*50-60% of all calls have some sort of mental illness attached to them*". Another stakeholder highlights that SDV "*is no one-and-done situation– it marinates. I believe everyone and no one in this work because it is so complicated*" (Table 2).

Domain 2: Outer Setting

The outer setting domain focuses on external factors impacting intervention efforts [19], including the added COVID-19 pandemic context construct. The patient needs and resources construct received the highest density of responses within the domain and provided insight into the unmet needs of community members. Specifically, stakeholders shared a need for emergency housing, mental health resources, substance use support, and increased staffing for the public health-public safety substance use prevention program. Barriers cited within the town included transportation, language barriers, and other organizations impeding access to services. For example, one stakeholder noted that accessing services in person can be difficult when a "*big problem in [the community] is transportation issues. Families might not have a car and the bus system is limited*" (Table 2). Additionally, stakeholders expressed a hesitancy to work with vital organizations like the Department of Children and Families (DCF) with one stating, "*Working with the DCF, they have resources but only for open cases. [It] may be beneficial to still have those resources without needing to open a case. Their resources are only in times of intense situations*."

Domain 3: Inner Setting

The inner setting focuses on internal factors of organizations that impact the implementation of an intervention [19], and interviews allowed respondents to explore the impact of SDV on the community before and since the COVID-19 pandemic (Figure 1). Specifically, one noted, "*Domestic violence has been growing steadily over the years, but this was even before COVID-19. [It] spiked during the beginning of COVID-19, but the spike has remained with calls – alcohol and drugs are involved*" (Table 2).

Additionally, stakeholders acknowledge the need for youth-focused prevention efforts for SDV, with one stating, "*If you're going to make a dent in the domestic violence problem, it needs to start with the kids, otherwise it'll be a repeating cycle*" (Table 2). While stakeholders acknowledged the benefits of existing programming, there was recognition that not enough resources are present to address crises such as SDV incidences. One stakeholder elaborated, "*Sometimes police officers take out of their own pocket and put people up in a hotel when they respond to a domestic violence call because there just aren't the resources*" (Table 2). Stakeholders suggested that the current partnership between public safety and public health could extend to address SDV in the community since it is a model that has worked for substance use.

Domain 4: Characteristics of Individuals

This domain focuses on the individual factors (i.e., thoughts, perceptions, beliefs, attitudes) that impact the success of implemented interventions [19]. Personal attributes had the highest density of responses for this domain, with stakeholders believing that families and children should be the primary focus for SDV efforts (Figure 1). One stakeholder noted, "*There needs to be more support for parents, especially for child behaviors since parents may not know how to deal with it*" (Table 2). Another stakeholder elaborated further on this point by stating, "*Kids in high school are learning this at home, they need to stop it here*" (Table 2). Furthermore, within the knowledge & beliefs about the intervention construct, multiple stakeholders raised themes of the effectiveness of existing public health-public safety programming in supporting community members, yet social problems remain a central focus for the town (Table 2).

Domain 5: Process

This domain focuses on the process and sustainability of implementation delivery and feedback through factors like planning, reflecting & evaluating, engaging, and executing [19]. Planning had the highest density of responses (Figure 1), with stakeholders identifying ways to welcome new families into the community to build connections among members and community organizations. Stakeholders also emphasized the importance of preventive measures against SDV within educational environments. For example, one stakeholder noted that addressing SDV requires "*Start[ing] with schools like at the high school level, or preferably lower, to show kids how they shouldn't treat somebody. The high school has done some domestic violence stuff but not enough or they no longer do it*" (Table 2). Reflecting on the growing diverse population within the community, another stakeholder found that "*Counselors that could work with the kids in multiple languages would be huge [including] how are they managing and what is happening. It's hard to connect with the families because we have that language gap*" (Table 2). A third stakeholder found that "*It is hard to analyze data because the coding is anonymous, and we don't know who are committing acts/repeated offenders*" (Table 2), suggesting a need for improved data communication and protocols in keeping records.

CFIR Domain[ab]				
Intervention Characteristics ***(Construct)***	**Outer Setting** *(Construct)*	**Inner Setting** *(Construct)*	**Characteristics of Individuals** *(Construct)*	**Process** *(Construct)*
Adaptability Need to adapt to the changing mental health climate by planning for long-term counseling both to children and families.	*Patient Needs & Resources* "Working with the DCF, they have resources but only for open cases. May be beneficial to still have those resources without needing to open a case.	*Implementation Climate* "Domestic violence has been growing steadily over the years, but this was even before COVID. Spike during the beginning of covid but the spike has remained with calls – alcohol and drugs are	*Personal Attributes* "There needs to be more support for parents especially for child behaviors since parents may not know how to deal with it." "From a domestic violence background, if you're going to make a dent in the DV	*Planning* "Start with schools like at the high school level, or preferably lower, to show kids how they shouldn't treat somebody. The high school has

	Their resources are only in times of intense situations." "Big problem in Winthrop is transportation issues. Families might not have a car and the bus system is limited."	involved." "If you're going to make a dent in the domestic violence problem it needs to start with the kids, otherwise it'll be a repeating cycle."	problem it needs to start with the kids, otherwise it'll be a repeating cycle. Try to show the effect of DV." "Kids in high school are learning this at home, they need to stop it here."	done some domestic violence stuff but not enough or they no longer do it." "Counselors that could work with the kids in multiple languages would be huge [including] how are they managing and what is happening. It's hard to connect with the families because we have that language gap."
Complexity "50-60% of all calls have some sort of mental illness attached to them." "Is no one-and-done situation– it marinates. I believe everyone and no one in this work because it is so complicated."	*Cosmopolitanism* "Winthrop has connections to resources outside of the community. […] is the local homeless agency, however, they don't do enough."	*Available Resources* "Sometimes police officers take out of their own pocket and put people up in a hotel when they respond to a domestic violence call because there just aren't the resources."	*Knowledge & Beliefs About the Innovation* The CLEAR program has been impactful for families and community members in bridging social issues with law enforcement. Social problems remain an area of focus in the community.	*Reflecting & Evaluating* "It is hard to analyze data because the coding is anonymous, and we don't know who are committing acts/repeated offenders."
Intervention Source Kids and teens are primary motivators to provide support to the community and families.	*External Policies & Incentives* "Once referral is made there are no feedback mechanisms to housing authority because of HIPPA."	*Networks & Communications* "There is limited access to the school department. There was no way to deal with the school department, they don't really work with us."	*Individual Stage of Change* "Whatever is going to benefit my students and their families that would motivate me to engage in programming."	*Executing* "We tell them what not to do but then they say well my mom smokes my dad hits and so we have to refocus on their own decisions as child versus adult."
Design Quality & Packaging The Winthrop CLEAR program has been effective in helping families and community members. "I've worked in Chelsea, Revere, Boston, and Dorchester… I know of no program like CLEAR."	*Peer Pressure* "In [Other Town] the […] program works with women to make them aware of their rights. This might be something to consider for Winthrop, especially in populations with the fear of police."	*Culture* "There is the Winthrop people and then the not Winthrop people (like families that are new to town). The families need a social network in the community."	*Individual Identification with Organization* "What has kept me in Winthrop is the resiliency within the community and community organizations."	
	COVID Contexts "Things being shut down impacted the socialization piece. People are more disconnected- as a whole and people's sense of safety."	*Tension for Change* "Catch 22 – try to be In front of it and be preventative but a lot of times we are answering the calls as they come in."		

[a]Quotes are stated as is unless to remove identifying information as indicated by […] or to make the statement clear as indicated by [*clarifying words*].
[b]Some quotes were not included for stakeholder confidentiality and instead general themes are provided.

Table 2: Exemplar quote from stakeholder interviews (n=8) on sexual and domestic violence by consolidated framework for implementation research (CFIR) domains and constructs.

Discussion

Given the shifting landscape resulting from COVID-19, efforts to raise awareness and allocate resources for SDV must adapt to better serve small, underserved communities. In a post-COVID-19 context, studying SDV in a community setting can help create interventions designed to address the pandemic's impacts. Notably, there has been a surge in cases of SDV alongside a significant decline in help-seeking behavior post-pandemic, underscoring the urgency for evolved strategies [12]. The purpose of this study was to explore themes and insights into SDV within a small, under-resourced community by integrating qualitative and quantitative methods to assess barriers to future implementation efforts [18]. Using a mixed-methods formative evaluation, the study identified gaps in awareness, access, and coordination of SDV resources, thereby informing targeted strategies for future programming within the community. To advise effective and sustainable efforts, this study actively engaged stakeholders with decision-making roles to understand their perceptions of the current state of SDV within their community [23]. While the sample size is small, it does represent multiple perspectives within the small town and presents a replicable approach to community-engaged research to assess perspectives and inform practice.

To issue actionable recommendations, input from diverse community decision-makers was organized using CFIR to identify strategic areas of improvement [19]. Quantitative findings supported by interview themes highlight the pandemic's role in increasing SDV, particularly linked to mental health and substance use. Given the complexity of SDV, which impacts many areas of practice, stakeholders emphasize the need for multi-sector collaboration. Stakeholders interviewed in this study agree that efforts around SDV are important, however, community gaps exist, such as a lack of emergency housing and prevention efforts. Collaboration among agencies can help bridge the existing gaps of resources noted by stakeholders. Additionally, stakeholders expressed a need for expanded data tracking and cross sector collaboration. to address the complexities of SDV and increase the speed of achieving shared goals [24]. Ultimately, these factors are central to effective program adoption, implementation, and sustainability [25].

Within the intervention characteristics domain, stakeholders identified gaps, including the need to enhance adaptability to support SDV as it relates to youth and mental health, highlighting the complexity associated with the SDV impact on individuals across the lifespan. This suggests a need to expand current programs to address the co-occurring social issues within the community [26]. In addition, protocols within agencies were found to be either poorly defined or vague in addressing SDV. Redesigning protocols requires examining current practices within agencies to determine where improvements are needed [25], specifically how to adapt existing protocols to a post-COVID-19 pandemic context [27].

Findings from the outer setting domain included gaps in resources such as emergency housing, mental health, and substance use support. Partnering with agencies that provide these resources can help facilitate change in addressing SDV [28]. In addition to shortages in these resources, stakeholders recognized barriers to services, including a lack of transportation and language differences [29]. SDV organizations can impact how individuals access their services, specifically, victims may perceive a fear of disclosing SDV and a lack of confidence in receiving help [30]. To close some of these gaps and perceived barriers, it is important to improve communication efforts between the agencies delivering these services and the community regarding current and future SDV intervention and prevention while also working to reduce the existing stigma that affects SDV survivors.

The inner setting domain identified the internal impacts of the COVID-19 pandemic, including resource and staffing shortages [31]. Since the start of COVID-19, wait times for emergency departments [32] and waitlists for emergency housing [33] have grown significantly. Further funding for timely resources, specifically emergency housing, is necessary to bridge the gaps of SDV survivors in the event they need to leave their environment [34]. In addition, stakeholders noted that there could be more preventative efforts, especially targeting youth. Examining existing agencies that can provide the necessary support to address prevention gaps can aid in supporting youth [35].

Insights from the characteristics of individuals domain found a large need for supporting families and children, specifically engaging youth-based organizations to emphasize SDV prevention. Developing a purposeful plan for engaging stakeholders proactively instead of reactively for SDV can help reduce the number of SDV incidences [36]. Such planning efforts should include perspectives of community members in SDV efforts to assess which are the most appropriate approaches [35].

Findings from the process domain found gaps in collaboration between agencies, particularly highlighting a lack of data sharing. In addition, some stakeholders noted that analyzing data itself is difficult. By developing an integrated data system across collaborators, data can be shared in a timely and comprehensive way to improve SDV efforts [37]. In addition, evaluating in-depth the communication between agencies can inform future best practices for interventions intended to enhance collaboration among agencies [38].

Recommendations and Lessons Learned

Insights from the mixed-methods evaluation led to recommendations in two areas: communication and collaboration and prevention efforts. These findings highlight the need for stronger inter-agency communication and coordination to improve SDV response, as well as enhance preventative strategies.

Communication and Collaboration

Key recommendations include enhancing collaboration and engagement among stakeholders from multiple sectors. Research has consistently shown that communication between various agencies is essential for effective collaboration and implementation of programs [28]. The benefits of communication across sectors include developing a collective vision, implementing an evaluation plan, and sharing data to inform decisions [39]. As highlighted previously, a significant gap in addressing SDV within the community was the absence of comprehensive and timely data-sharing mechanisms. Therefore, implementing an integrated system to address these

barriers is paramount in bolstering SDV strategies and initiatives [37]. Such a system would not only facilitate seamless information exchange but also foster stronger relationships and collaborations among agencies, leading to more coordinated and impactful interventions in combating SDV.

Prevention Efforts

Engaging stakeholders throughout all stages of implementation is crucial for promoting awareness and adoption of SDV prevention programs within a community [40]. One effective strategy is targeting youth and families, as highlighted by stakeholder interview responses. To support these efforts, examining existing agencies capable of addressing prevention gaps is essential, particularly to mitigate the lasting harms of SDV [35]. Collaborating with youth-based organizations helps to prioritize SDV prevention among young people, aligning with research emphasizing early intervention [35]. Proactively engaging stakeholders in a strategic plan for SDV prevention is key to reducing its incidence rates [36]. This planning should involve gathering community perspectives to determine the most effective prevention approaches [35]. By prioritizing prevention strategies and early stakeholder engagement, communities can create safer environments and better support individuals vulnerable to SDV.

Implications

This study highlights future directions for both research and practice. Future research should explore incorporating community input to ensure SDV initiatives are culturally sensitive, well-informed, and tailored to the needs and preferences of those directly affected. Future practice-based efforts should include enhancing stakeholder collaboration and communication by establishing shared goals and improving data-sharing methods. Undergoing a community-based formative evaluation can help in both of these areas to access perspectives from the community while at the same time connecting important stakeholders and decision-makers to collaborate on a comprehensive approach to addressing SDV.

Advancing SDV efforts involves collaborating closely with stakeholders who possess decision-making authority. The stakeholders within this study, drawn from diverse agencies, were selected for interviews and surveys precisely because of their visibility and influence in the community. Notably, a significant majority of respondents (80%) reported having partial decision-making authority regarding participation in programs targeting SDV prevention and mitigation.

Incorporating community input is essential to understand the range of perspectives that will influence implementation efforts. These insights guide the development of targeted and culturally sensitive strategies and help identify ways to reduce stigma that align with the community's values and priorities. By seeking and valuing community input, SDV initiatives gain legitimacy, and relevance, and ultimately have a greater impact on the community [35]. This collaborative approach ensures that interventions are well-informed and tailored to the specific needs and preferences of those directly affected by SDV.

Strengths and Limitations

This study leverages the CFIR to identify gaps and barriers related to addressing SDV, with a particular focus on the impact of COVID-19 and potential areas for expansion. By adopting a mixed-methods approach, the study benefits from a diverse range of perspectives from stakeholders across various agencies involved in SDV efforts. This inclusivity allows for a comprehensive understanding of the challenges and opportunities in the field. The study has some limitations that should be noted. First, the small sample size (n=8) means that the perspectives and opinions gathered may not be representative of all agencies or staff involved in SDV initiatives. This is a challenge of practice-based research, but we ensured that perspectives from multiple stakeholders were incorporated. Additionally, the methodology to engage multiple stakeholders in a community can provide best practices for other communities interested in community-engaged approaches to exploring the context for program and policy design and implementation. Second, relying on self-reported data and lacking validated measures in surveys and interviews can introduce bias and limit the generalizability of the findings beyond the specific community studied. Finally, this study was on one community with a very specific context. Our goal was to explore that context through a methodological approach that can be replicated in other communities interested in stakeholder-engaged research to inform practice. Despite these limitations, the study's strengths lie in its ability to tailor recommendations directly to the community of interest. The diverse perspectives provided by stakeholders offer valuable insights and angles into SDV efforts, contributing to a nuanced understanding of implementation challenges and potential solutions. The use of the CFIR also aids in distilling multiple perspectives into actionable recommendations, enhancing the study's impact on informing change within the community of focus.

Conclusion

This study extensively explored the themes and insights surrounding SDV within a community, employing a mixed-methods approach to assess barriers to future implementation efforts. The findings emphasized the critical need for community decision-makers to inform best practices in a post-COVID-19 landscape, given the sharp rise in SDV cases and the concerning decline in help-seeking behavior. Efforts must be intensified to enhance awareness, allocate resources strategically, and foster collaboration across sectors, particularly in addressing critical gaps such as emergency housing, prevention initiatives, and data-sharing protocols.

By employing a methodological approach that engaged a diverse range of stakeholders, the study was able to offer valuable insights, paving the way for tailored recommendations and impactful change within the community. Ultimately, the findings serve as a solid foundation for developing and implementing more effective SDV interventions that are finely tuned to the specific needs and perspectives of stakeholders and the community contexts.

Ethical Approval

This study has been reviewed and determined as an exempt study by the Boston University Institutional Review Board (IRB #H-44120). All methods and protocols were performed in accordance with the guidelines from the Boston University Institutional Review Board and given the exempt study status. The Boston University Institutional Review Board reviewed the research and determined that it was not human subjects research and therefore had no requirement to obtain consent.

Availability of supporting data

The interviews and data for this study are not publicly available due to privacy, confidentiality, and anonymity considerations, but data that support the findings of this study are available from the corresponding author upon request.

Competing interests

The authors have no competing interests to declare that are relevant to the content of this article.

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Author Contributions

BE led data collection and qualitative analysis and drafted the manuscript. MH and SG participated in the design of the study and stakeholder analysis. MV, SC, SF, and JG conducted qualitative data analysis and reviewed manuscript drafts. AF conducted quantitative data analysis and drafted the manuscript. AC and GR assisted in preliminary research, data analysis, and manuscript review. JG conceptualized the study, oversaw data collection and analysis, and drafted and reviewed manuscript drafts. All authors contributed to the article and approved the submitted version.

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References

1. Huecker MR, King KC, Jordan GA, et al. (2023) Domestic Violence. StatPearls Publishing.
2. Peterson C, Kearns MC, McIntosh WL, et al. (2018) Lifetime economic burden of intimate partner violence among U.S. adults. Am J Prev Med 55(4): 433-444.
3. Cho H (2012) Examining gender differences in the nature and context of intimate partner violence. J Interpers Violence 27(13): 2665-2684.
4. Haselschwerdt ML, Hardesty JL (2017) Managing secrecy and disclosure of domestic violence in affluent communities. J Marriage Fam 79(2): 556-570.
5. Piquero AR, Jennings WG, Jemison E, et al. (2021) Domestic violence during Covid-19 evidence from a systematic review and meta-analysis. J Crim Justice.
6. Whiteman PJ, Macias-Konstantopoulos WL, Relan P, et al. (2023) Violence and abuse: A pandemic within a pandemic. West J Emerg Med 24(4): 743-750.
7. Lluch C, Galiana L, Doménech P, et al. (2022) The impact of the COVID-19 pandemic on burnout, compassion fatigue, and compassion satisfaction in healthcare personnel: A systematic review of the literature published during the first year of the pandemic. Healthcare 10(2): 364.
8. Babalola T, Couch T, Donahoe M, et al. (2022) Domestic violence calls for police service in five US cities during the COVID-19 pandemic of 2020. BMC Public Health 22(1): 2455.
9. Hair NL, Urban C (2023) Association of severe COVID-19 and persistent COVID-19 symptoms with economic hardship among US families. JAMA Network Open 6(12): e2347318.
10. Horigian VE, Schmidt RD, Feaster DJ (2021) Loneliness, mental health, and substance use among US young adults during COVID-19. J Psychoactive Drugs 53(1): 1-9.
11. Wright EN, Anderson J, Phillips K, et al. (2022) Help-seeking and barriers to care in intimate partner sexual violence: A systematic review. Trauma Violence Abuse 23(5): 1510-1528.
12. Muldoon KA, Denize KM, Talarico R, et al. (2021) COVID-19 pandemic and violence: Rising risks and decreasing urgent care-seeking for sexual assault and domestic violence survivors. BMC Med 19(1): 20.
13. CDC (2024) About the public health approach to violence prevention. Violence Prevention.
14. Fulambarker A (2020) "Everybody loses": Understanding police roles and perceptions of domestic violence calls. Journal of Qualitative Criminal Justice & Criminology.
15. Remiker M, Sabo S, Jiménez D, et al. (2021) Using a multisectoral approach to advance health equity in rural arizona: Community-engaged survey development and implementation study. JMIR Form Res 5(5): e25577.
16. Creswell JW (2013) Qualitative inquiry and research design: choosing among five approaches. SAGE.
17. Smith SG, Chen J, Basile KC, et al. (2017) National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 state report. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA.
18. Bangham C, Cunnington S, Fielman S, et al. (2023) Using formative evaluation of a community-based opioid overdose prevention program to inform strategic communication for adoption, implementation, and sustainability. BMC Public Health 23(1): 341.
19. Damschroder L, Aron D, Keith R, et al. (2009) Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. Implementation Sci 4: 50.
20. Damschroder LJ, Reardon CM, Widerquist MAO, et al. (2022) The updated Consolidated Framework for Implementation Research based on user feedback. Implement Sci 17(1): 75.
21. Freeman RE (2010) Strategic Management: A Stakeholder Approach. Cambridge University Press.

22. Prochaska JO, Norcross JC (2002) Stages of Change. In Psychotherapy relationships that work: Therapist contributions and responsiveness to patients. Oxford University Press, pp: 303-313.
23. Minogue V, Wells B (2018) Adding value, reducing research waste, the role of the NHS research and development management community. Int J Health Gov 23(2): 160-177.
24. Wang X, Matone M, Garcia SM, et al. (2024) A social network analysis of a multi-sector service system for intimate partner violence in a large US city. J Prev 45(3): 357-376.
25. Bryson JM, Crosby BC, Stone MM (2015) Designing and Implementing Cross-Sector Collaborations: Needed and Challenging. Public Administration Review 75(5): 647-663.
26. Brewer, S., Godley, M. D., & Hulvershorn, L. A. (2017). Treating Mental Health and Substance Use Disorders in Adolescents: What Is on the Menu? Current Psychiatry Reports, 19(1), 5. https://doi.org/10.1007/s11920-017-0755-0
27. Ovretveit, J., Mittman, B. S., Rubenstein, L. V., & Ganz, D. A. (2021). Combining Improvement and Implementation Sciences and Practices for the Post COVID-19 Era. Journal of General Internal Medicine, 36(11), 3503–3510. https://doi.org/10.1007/s11606-020-06373-1
28. Salunke, S., & Lal, D. K. (2017). Multisectoral Approach for Promoting Public Health. Indian Journal of Public Health, 61(3), 163. https://doi.org/10.4103/ijph.IJPH_220_17
29. Williams ME, Perrigo JL, Banda TY, et al. (2013) Barriers to accessing services for young children. J Early Intervention 35(1): 61-74.
30. Heron R, Eisma M (2021) Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research. Health Soc Care Community 29(3): 612-630.
31. Pinto JK (2022) Reassessing project practices, research, and theory in a post-Covid reality. International Journal of Information Systems and Project Management 10(4): 5-27.
32. Alharthi S, Al-Moteri M, Plummer V, et al. (2021) The Impact of COVID-19 on the Service of Emergency Department. Healthcare 9(10): 1295.
33. Acosta S, Guerrero B (2021) Long Waitlists for Housing Vouchers Show Pressing Unmet Need for Assistance. Center on Budget and Policy Priorities.
34. Arroyo K, Lundahl B, Butters R, et al. (2017) Short-term interventions for survivors of intimate partner violence: A systematic review and meta-analysis. Trauma Violence Abuse 18(2): 155-171.
35. Kingston BE, Zimmerman MA, Wendel ML, et al. (2021) Developing and implementing community-level strategies for preventing youth violence in the United States. Am J Public Health 111(1): S20–S24.
36. Edwards KM, Neal AM, Rodenhizer-Stämpfli KA (2017) Domestic Violence Prevention. In B. Teasdale & M. S. Bradley (Eds.), Preventing Crime and Violence Springer International Publishing, pp: 215-227.
37. Lin CP, Black RA, LaPlante J, et al. (2010) Facilitating health data sharing across diverse practices and communities. Summit Transl Bioinform pp:16-20.
38. Sylvestre J, Cousins JB, Sundar P, et al. (2008) Engaging stakeholders in the planning of a collaborative multi-agency evaluation: The HousingPlus Collaborative Communities Project. Studies in Educational Evaluation 34(4): 212-217.
39. Amri M, Chatur A, O'Campo P (2022) An umbrella review of intersectoral and multisectoral approaches to health policy. Soc Sci Med 315: 115469.
40. Weiner BJ, Lewis CC, Sherr KH (2023) Practical implementation science moving evidence into action. Springer Publishing Company, LLC.

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