The Intimate Partner Violence Triage Study

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The Intimate Partner Violence Triage Study will produce information for service providers of all kinds, including particularly legal services providers asked to represent victims of intimate partner violence (“IPV”) at adversarial restraining order hearings, on a critical question: how should we triage clients to different levels of service when resources are severely constrained? Currently, in northeastern Ohio, a legal aid provider’s resources are sufficient to provide traditional attorney-client representation to approximately one-third of eligible IPV victims who seek permanent restraining orders in adversarial court hearings. One third of such victims receive only self-help assistance materials, and one-third receive self-help assistance materials plus an explanatory telephone call. In the Study, eligible and consenting IPV victims will be randomized to one of two triage decision making processes, either the provider’s current process or a random process. A comparison of the adjudicatory outputs and the post-court experiences of victims in each group will provide information on the effectiveness of the legal aid provider’s current triage process. Further, the randomized arm of the study will allow several other direct and (through the use of instrumental variables techniques) indirect measurements of interest.

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BACKGROUND AND SIGNIFICANCE

Few things are more detrimental to physical and mental health than getting beaten up. And while getting beaten up is always traumatic, an assault by someone who was previously trusted, revered, and loved is perhaps the worst form of nonlethal violence imaginable. To achieve physical and psychological health after being violated, adult survivors of domestic violence, sexual assault, and stalking must overcome stubbornly persistent impediments: from the constant fear of being killed or beaten up again, to the hyper-vigilance born of surviving sexual assault, to the actual physical injuries sustained (e.g. Mitchell & Anglin eds. (2009)). Organizations as diverse as the Center for Disease Control (CDC (undated)) and the U. S. Department of Justice (NIJ (2001)) have recognized the threat that domestic violence poses to public health. As the CDC's 2010 National Intimate Partner Violence Survey documented, this public health problem is widespread, with nearly one in five women reporting that they had been raped in their lifetimes (CDC (2010)). The mental and physical health effects of domestic abuse, sexual assault, and stalking are both extensive and similarly well-documented (see Campbell (2002), Devries et al. (2013), Golding et al. (1997) for reviews. Statistics are too numerous even to summarize, but unsurprisingly, intimate partner violence, sexual assault, and stalking of adult women has been linked to a host of mental (e.g., Beydoun et al. (2012), Golding et al. (1997)) and physical conditions, including suicides (Devries et al. (2013), McLaughlin (2012)) along with “headaches, back pain, sexually transmitted diseases, vaginal bleeding, vaginal infections, pelvic pain, painful intercourse, urinary tract infections, appetite loss, abdominal pain, . . . digestive, . . . gynecological, chronic stress-related, central nervous system, and total health problems” (Campbell et al. (2002)). Effects may continue in the next generation, with multiple papers finding an association between abuse during pregnancy and low birth weight (see Murphy (2001) and Shah & Shah (2010) for meta-analyses). Patients/victims are often revictimized, with strongly negative effects on mental health, including post-traumatic stress disorder (Walsh et al. (2012)).
In the United States, one primary tool to combat the public health problem of domestic violence is not medicinal but legal. Every state has established a system of court hearings by which a victim of domestic violence may seek a protection order (a “PO”) (ABA (2009a), ABA (2009b)), and public health specialists describe POs as “life-saving interventions” (McCaw & Kotz (2009)). Although their terms vary, typical POs prohibit the alleged perpetrator from continuing the abuse, mandate that abuser-victim contact take place only in circumscribed conditions, or require that the abuser maintain a physical distance from the victim (ABA (2009a)). If a perpetrator complies with a PO, then the order provides the tranquility and security the victim needs to begin the process of returning to mental and physical health (Buel & Hirst (2009)). If a perpetrator does not comply with a PO, then the order provides the basis for subsequent police intervention and protection. For example, depending on a PO’s terms, a police officer may be able to arrest a perpetrator for approaching too close to a victim, something far easier to prove than, say, menacing behavior or verbal intimidation. Obtaining a PO is thus a critical first step toward recovering physical and psychological health, and the significance of our public health question lies in our investigation, detailed below, of the effectiveness of this critical public health tool, as well as of how to maximize access it. Our research thus answers calls for “evaluating [Intimate Partner Violence] preventive strategies” coming from public health officials, neuroscientists, epidemiologists, emergency medicine doctors, law professors and legal clinicians, and practicing attorneys (e.g., Beydoun et al. (2012), Buel & Hirst (2009)).

Which patients/victims can obtain POs? One might think a PO, like a childhood vaccine, would be available to any person who needs one. Not so. In the United States, because the alleged perpetrator has liberty interests at stake, obtaining a PO requires a formal court proceeding, at which the victim bears the burden of producing sufficient evidence while complying with complicated evidentiary and procedural rules (see, e.g., Ohio Revised Code section 3113.31). The navigability of a formal court proceeding, a subject generally known as “access to civil justice,” thus becomes an issue of public health in the PO context. Indeed, the Department of Justice has gone so far as to issue guidance documents requesting that
physicians take steps to make their medical records more readily admissible in subsequent court proceedings (NIJ (2001)).

But if the court-issued PO is the medicine that provides a patient/victim with what she needs to recover and heal, then at least for a low- or lower-income individual, the civil legal aid attorney plays the role of the doctor who provides access to that medicine. Navigating a formal court proceeding is no more familiar to an uninitiated patient/victim than is administering a shot. Neither is easy to do by oneself, to oneself.

Unfortunately, in their roles as the doctors of the PO process, legal aid attorneys operate under unusual constraints. Because PO hearings are civil, not criminal, matters, the oft-quoted mantra “If you cannot afford a lawyer, one will be appointed to represent you” does not apply. Thus, there is no dedicated government budget to hire attorneys to provide full representation to low-income patients/victims who need POs, the way there is, for example, to fund the public defenders who represent criminal defendants. For decades, civil legal aid attorneys have operated with funding that is, by any measure, insufficient for the need. Specifically, legal aid organizations are able to offer a traditional attorney-client relationship only to a fraction of otherwise eligible patients/victims who desire POs (LSC (2009)). In 2013, for Community Legal Aid Services, Inc. (“CLA”), a non-profit organization operating in eight counties in Northeast Ohio, this fraction was around one third, meaning two thirds did not get “a lawyer” in the sense that the public usually understands the phrase “having a lawyer.” CLA provides patients/victims to whom it cannot offer a traditional attorney-client relationship two other forms of assistance. To about one third of those desiring POs, CLA provides guidance on how the patient/victim can go forward without an attorney, with information about the court process and specific advice related to the participant’s individual situation, via a 30-minute explanatory telephone call from an attorney and/or a lengthy follow-up letter. By the time the study proposed here commences, CLA, with the assistance of Professor Jim Greiner from Harvard Law School, will have developed and have begun dispensing with the explanatory phone call a self-help assistance packet designed for persons desiring POs. For the final one third, resource constraints prohibit even the explanatory call; at present, CLA may suggest that the patient/victim request a court
continuance and call CLA again to see if it is able to assist on the new court date. In the alternative, patients/victims may get no assistance at all. Again, by the time the study proposed here commences, CLA will have begun dispensing its self-help assistance packet to such patients/victims.

Accordingly, as the doctors of the PO process, CLA staff are less like traditional physicians and more like Navy Corpsmen evaluating the survivors of a pitched battle. The Navy Corpsmen’s Manual instructs Corpsmen in such “tactical” situations to conduct triage: Corpsmen must identify a first class of patients “for whom definitive treatment can be delayed without jeopardy to life or loss of limb;” a second class “whose wounds or injuries would require extensive treatment beyond the immediate medical capabilities”; and a third class “whose injuries require immediate life-sustaining measures.” Corpsmen are instructed that when time and resources are not sufficient to treat all, the third class receives treatment. Resources expended on the first or second class are resources that are “wasted” in the sense that they will not make a difference in preserving health. And in a triage setting, wasted resources mean lost lives in the third class, patients for whom treatment will make a difference (U.S. Navy (undated)).

The analogy to what all civil legal aid lawyers, including CLA’s staff, do in the PO context is direct: some victims have the self-motivation, organizational skills, and persuasive powers to obtain POs on their own without a full attorney-client relationship; they are analogous to the first class of injured servicemen identified above, and offering an attorney-client relationship to members of this class wastes resources others desperately need. Meanwhile, some patients/victims are too terrified to testify on their own behalves, or are to psychologically dependent on their abusers, such that they will not allow an attorney to represent them effectively; such hopeless cases are analogous to the second class of servicemen identified above, and again, offering an attorney-client relationship to members of this class wastes resources others desperately need. Only the third class, those patents/victims who would obtain POs with legal representation, but who would not obtain them without representation, should be offered full attorney-client relationships.
From this understanding comes the **first research question of our proposal**: do legal aid attorneys and paralegals triage well? Currently, CLA makes its triage decisions as follows: a paralegal or an intern obtains information about a patient/victim's background, case circumstances, profile and history of abuse, extent of physical and psychological damage, economic circumstances potentially indicative of dependency on the abuser, presence of children, *etc*. CLA staff combine this information with their knowledge of the eight county court systems in which it operates. CLA then makes a human judgment as to whether a full attorney-client relationship is in the first, second, or third class identified above, and offers full representation to those believed to be in the third.

As much as we at CLA hate to admit it, there is reason to doubt the efficacy of our triage judgments. We are human. “Biases” (meaning departures from purely rational decision making) may be at work. For example, the well-documented phenomenon labeled “identified versus statistical lives” may cause a member of our staff to triage patients/victims she has personally met to full representation, passing over those she has not met (Cohen et al. eds. (forthcoming 2014)). Or, a particular patient/victim might have a mental health issue or an unusually difficult personality, causing the attorney to misclassify that person into the second rather than third group, even though that mental health issue or difficult personality (in a courtroom setting) is precisely what might make full representation so important.

Even if we were perfectly rational, are we eliciting the right information in our intake system? For example, one might hope that educational level would be predictive of an individual’s ability to manage by herself in adjudicatory proceedings, but one recent study in unemployment adjudications found that educational level had no predictive power (Greiner and Pattanayak (2012)). We may be perfectly capable decision makers, but if we are asking the wrong questions at intake, then we are basing our decisions on the wrong information, and we will not get the right results.

Thus, we return to our **first research question**: is human triaging effective in the PO context? Do legal aid providers allocate scarce attorney-client relationship time to the third class of victims/patients who will benefit from the greater expenditure of resources involved, *i.e.*,
those who will obtain a PO with a traditional attorney-client relationship but not obtain one with either of our two lower levels of assistance (self-help packet plus telephone call, self-help packet alone)?

Our research question is national in scope. Legal services providers across the country working in domestic violence, sexual assault, and stalking face the same resource constraints, the same necessity for triage, and thus face the same questions triage efficacy. Looking more broadly, there is growing evidence of, and indeed a flourishing national movement explicitly founded upon the powerful relationship between public health and legal problems (National Center for Medical Legal Partnership (2014)). But our national legal aid structure has resources to offer less than one half of eligible persons a civil legal problem involving a basic human need any form of assistance, much less a full attorney-client relationship (Legal Services Corporation (2009)). Across the nation, in the civil legal aspects of public health, triage isn’t everything, it’s the only thing. And despite the centrality of triage in our civil legal aid system, with its central implications for public health, we are aware of no evaluation, rigorous or otherwise, of any kind of any triage system.

We propose a randomized control trial (“RCT”) investigation into triage mechanisms in the PO context. The design of our study is straightforward (see the flow chart below for a pictorial representation): victims of domestic violence will enter CLA’s intake system and be screened for eligibility for our services. After providing consent to participate in the study, they will be randomized to one of two triage protocols. Triage Protocol One is our current system of human decision-making, based on the background information we gather and our own impressions. In other words, in Triage Process One, one of our paralegals or attorneys will assign each patient/victim to receive an offer of a full attorney-client relationship, a self-help packet plus an explanatory telephone conversation, or a packet alone. Triage Protocol Two, in contrast, is a roll of a die, meaning that a second round of randomization will decide whether the particular patient/victim receives an offer of a full attorney-client relationship, a self-help packet plus an explanatory telephone conversation, or a packet alone. Our specific, testable hypothesis that is the aim of our study: If CLA is triaging well, we should see more POs and
greater human health (as measured by a proxy measurement explained below) among patients/victims in Protocol One vis-à-vis those in Protocol Two. As we conduct our study, we will document what information CLA gathered and the basis for each human triage decision. With this information available, if it turns out that CLA is not triaging well, we can investigate whether Castoff judgments are faulty, or whether CLA is not collecting the right information, or whether something else is amiss.

Meanwhile, if (as we believe to be the case) patients/victims with full representation are substantially more likely to obtain POs than those without such representation, we can deploy standard instrumental variables techniques within our Protocol Two group to explore a second research question: how much does obtaining a PO improve patient/victim health? As noted above, an entire legal structure is built on the assumption that POs improve public health, and we believe that this assumption is true. But this legal structure imposes monetary, temporal, and psychological costs on those who use it and those who run it. As a first step toward discerning whether these costs are worth the benefits, we will provide a randomization-based estimate of the health benefits of the PO system. No additional data collection will be needed.

The potential impact of our study results are numerous and far-reaching. As noted above, triage is the only thing in the civil legal aspect of public health. The assumptions of good triage, and the effectiveness of POs on public health, form the basis of the funding decisions made by the Federal Government, through Department of Justice Legal Assistance to Victims grants; by State Governments, through Victims of Crime Act grants; and by numerous local and regional non-profit organizations, including community foundations and United Way organizations. Local court systems are heavily invested in ensuring that victims have access to the courthouse to seek the POs that potentially provide them (and their families) with relief from the physical violence, psychological trauma, and ongoing stress of their victimization. All aspects of these legal efforts depend on triage and on the assumption that POs improve public health; our study will be the first to assess the health effects of these laws.

METHODS, MEASURES AND ANALYSIS
The applicant on this Proposal is CLA. CLA was founded in 1952 and currently deploys approximately 28 attorneys to provide free legal services on a wide range of matters in eight northeastern Ohio counties. CLA has for decades worked daily with the service population in this study: battered women, victims of domestic violence, victims of sexual assault, and victims of stalking. At present, to service this population, CLA has two paralegals, three full-time attorneys, two other attorneys who dedicate a portion of their time, and interns. In implementing the present proposal, CLA will draw its years of experience with the victims and the court systems involved. Primary partners on this Proposal (budgetarily classified as vendors who will sign memoranda of understanding) are Professor Jim Greiner of Harvard Law School and various domestic violence shelters, rape crisis centers, and Sexual Assault Nurse Examiners (“SANE”) units with which CLA has built, and is continuing to build, strong relationships. In addition to his position at Harvard Law School, Professor Greiner holds a courtesy appointment in the Harvard Department of Statistics; he and his team have completed or are fielding six RCTs in the areas of access to justice and court administration (e.g., Greiner & Pattanayak (2012); Greiner et al (2013); Greiner et al. (2014)). Professor Greiner has been and will be intimately involved with all aspects of the design, implementation, and analysis of this study. A list of domestic violence shelters, rape crisis centers, and SANE units with which CLA works daily is available upon request.

Our research design is among the strongest available to discern the health effect of law, an anonymized randomized experiment, as follows. Patients/victims of domestic violence or sexual assault who desire to obtain POs will enter CLA’s intake system through a variety of mechanisms (referrals, direct contacts, etc.). At the time of intake, most victims will have already obtained temporary, court-issued orders of protection through an “ex parte” (meaning that is the alleged perpetrator is not present) legal proceeding. But these temporary orders of protection, which by law typically expire after a short period of time, should not be confused with the more durable POs that are the subject of this Proposal. The latter POs that are the subject
of this study last longer, can contain more extensive and more tailored provisions, and may be renewed.

Upon receiving an intake case, a CLA paralegal or attorney will arrange for any missing information to be collected and, via a telephone or in-person conversation, will obtain informed consent to participate in the our randomized study. Note that randomization is ethical in this context because there is a shortage of a particular resource (the attorney and paralegal time required for full representation and telephone advice) (Greely (1977)) and because, given the total absence of any reliable evidence about the efficacy of triage protocols, we are in equipoise (e.g., Lilford & Jackson (1995)) about the benefits of human decision making in this area. A completed intake file will include at least the following information: variables coding the extent and nature of the victims physical injuries; variables coding her prior history (if any) of victimization; variables coding her knowledge of, and prior experience with, the court system; variables coding her educational level, literacy, and facility with the English language; variables coding basic demographic information (e.g., age, race, gender); the county in which she lives (each of the eight counties has its own court system); and certain subjective assessments, such as an impression of her ability to pursue a PO on her own.

Once the intake file is complete, a CLA staff member will make a provisional triage decision, a decision not to be communicated to others within CLA, hypothetically assigning the particular patient/victim to one of three treatment levels: Level A is an offer of a full attorney-client representation in the PO process. Level B is self-help assistance packet together with an attempt to provide the patient/victim with a 30-minute telephone call walking her through the PO process in her county and providing advice on how to succeed. Level C is the self-help assistance packet alone. Note that the CLA staff member will make a provisional level-of-service decision before randomization of the patient/victim to a triage protocol so as to assure that the triage protocol randomly chosen cannot affect the level-of-service decision.

CLA staff will transmit the information in the intake file, together with the provisional level-of-service decision, to Professor Greiner’s team at Harvard Law School. Any personal identifying information will be removed from this transmission and replaced by a unique study ID.
number, thus walling off research staff from patient/victim identity. Professor Greiner will then randomize the patient/victim to one of two triage protocols. If the randomizer chooses Triage Protocol One, the CLA’s provisional level-of-service decision will be accepted. In other words, if the CLA staff had previously and provisionally assigned patient/victim Smith to Level B, 30-minute telephone call plus packet, and if the randomizer selects Triage Protocol One, then Smith will in fact be assigned to Level B. If, in contrast, the randomizer selects Triage Protocol Two, then Professor Greiner will disregard the original CLA level-of-service decision and will randomize the case a second time to select a level of service (A, B, or C). Professor Greiner will, obviously, record both the Triage Protocol used and the level of service assigned.

Professor Greiner will then report to CLA only the level of service that should be provided to the patient/victim, not the Triage Protocol used, to CLA.  

CLA will offer the patient/victim the level of service according to Professor Greiner’s instruction. In all but the most exceptional of cases, these services will be delivered quickly, and the results will be quickly evident. Like the Navy Corpsmen mentioned previously, CLA staff operate in an environment in which services ordinarily must be delivered rapidly or not at all.

Victims of domestic violence, stalking, and sexual assault are in danger, perhaps the most danger, from the time they resolve to seek a PO to the time that they either obtain one (or fail to do so). Although cases vary, ordinarily, the time period from a complete intake to entry of a PO (if one is ever entered) is seven weeks or less.

CLA and Professor Greiner obtain two, primary outcome measurements. The first is whether the patient/victim obtains a PO. The discussion above demonstrates why this outcome is consequential for public health. With respect to our data collection plan, entry (or lack thereof) of POs is available from court records. CLA and Professor Greiner will also code several secondary outcomes, such as the duration of the PO, or whether it includes a

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4 CLA and Professor Greiner held thorough discussions regarding the feasibility of blinding CLA staff to the triage protocol used. In fact, the design above results in blinding for two-thirds of all study cases (details can be provided upon request). Ultimately, however, complete blinding was not operationally feasible because it would have required that the CLA attorney who made the level-of-service decision for a particular patient NOT provide services to that patient. To increase familiarity with and knowledge of the court systems in each county, however, CLA allocates its staff regionally, and resources are not sufficient to have more than one attorney or paralegal in each region.
requirement that the perpetrator maintain a “halo” of physical distance away from the victim. Additional variables include the number of motions filed, the nature of court hearings held, the length of time needed to obtain a PO, and the judge who issued it. Law student research assistants working under Professor Greiner will code case files into spreadsheets.

Our second outcome measure is our direct measure of health: whether within one year of randomization the patient/victim seeks new, additional post-randomization assistance from a shelter, a rape crisis center, a SANE unit, CLA itself, or the court system. We refer to this measurement as “protective service reaccess,” and we have selected it as our direct measure of health after careful consideration of other possible measurements. We explain here why we rejected three other potential measures. Our first thought was to seek self-reported health information, via surveys, from patients/victims themselves. We rejected this thought for multiple reasons. CLA’s decades of experience with its client base demonstrates that low-income battered women and victims of stalking or sexual assault move frequently from one place to another, often in an effort to escape their batterers (although they do not typically move out of the counties in which they are living). Good addresses are thus hard to come by. Meanwhile, other forms of communication, such as cell phones, can become vectors for abuse. Under these conditions, survey non-response would likely be prohibitively high. Further, CLA’s experience led us to believe that feelings of shame, guilt, and powerlessness would prevent patients/victims from responding truthfully in surveys they did return.

Another thought was to seek police records of incidents involving each patient/victim. We will in fact attempt to collect this information, from which we can code, for example, whether a police report of some domestic abuse, stalking, or assault by the original perpetrator against the patient/victim was reported subsequent to randomization. But CLA’s extensive knowledge of the behavior of its client population leads us to be skeptical that such information would be as revealing of health status as protective service reaccess. The simple reason is that feelings of shame, guilt, and powerlessness, along with mistrust of police officers, often prevent patients/victims from seeking police assistance; Catalano (2007) documents this phenomenon nationally in the context of intimate partner violence. Further, we think it unlikely that a
patient/victim would seek police protection without also seeking assistance from a shelter, a crisis center, a SANE unit, CLA, or the court, so police records will probably tell us little that we cannot glean from these other sources in which we have greater confidence.

Next, we considered seeking (pursuant to appropriate permissions and waivers, which we are confident that we could obtain) information from health care provider records. We rejected this idea for the same reason as we are reluctant to rely on police records: CLA’s experience demonstrates that patients/victims routinely eschew treatment from the formal health care system, even when such treatment is badly needed. CLA’s experience on this score is consistent with national data from the National Center for Injury Prevention and Control. According to the this center’s 2003 National Violence Against Women Survey, fewer than 12% of victims of either rape or physical assault received any medical care at all (NCIPC (2003)).

What patients/victims will do is seek assistance from domestic violence shelters, rape crisis centers, SANE nurses, CLA, or the courts (especially if they have POs in place). Indeed, the patients/victims who enter our study will ordinarily have already sought assistance from one or more of these service providers, so reaccess is a low-information-cost proposition for them. As evidenced by the letters of support attached to this application from the shelters, centers, and SANE units (courts do not readily write such letters), CLA has strong relationships with all of these entities, so we have confidence that CLA will be able to measure protective service reaccess accurately. Our data collection plan, then, is to obtain information from these entities, which will be provided in de-identified form to Professor Greiner and his team.

We anticipate that we will be able to enroll 1200 patients/victims over three years of intake and to have results at year four. Our projection of 400 patients/victims per year over three years is based on CLA’s previous record of assistance to this same service population in the year 2013; we anticipate slightly higher case volume but have kept our estimates conservative. With respect to our data analysis plan, Professor Greiner and his team will begin by addressing the issues of missing data and randomization checks. Regarding the former, Professor Greiner and his team will deploy the statistical method known as “multiple imputation” (Rubin (1978), Rubin & Little (2002)) to fill in missing values multiple times,
producing (say) five “completed,” rectangular datasets that can be analyzed with any statistical
software package. Results from the multiple datasets can be combined with now-standard
combining rules to produce overall estimates (id.). With respect to randomization tests,
Professor Greiner and his team will use permutation methods to assess whether the
randomization produced treated (Triage Protocol One) and control (Triage Protocol Two) groups
identical, apart from random variation, on background variables. Once missing data and
randomization issues are addressed, the strong research design in this study will allow
Professor Greiner and his team to produce causal estimates using rudimentary difference-in-
rates comparisons and permutation tests. Professor Greiner and his team will also use
Bayesian linear and GLM regression to produce model-based estimates of causal effects.

Regarding statistical power, applying the “highly conservative” Bonferroni multiple testing
penalty (e.g., Kaasinen et al. (2001)) to our two primary outcome 0-1 variables (i.e., PO,
protective service reaccess), and assuming a worst case scenario in which outcomes have base
rates of around 50%, we will have over an 80% probability of detecting differences of ten
percentage points or larger (two-sided test). These figures assume no increase in precision
from the modeling outlined above, even though the richness of the intake variables we will
collect may provide the opportunity for substantial modeling-based precision gains at relatively
low risk. But if modeling proves unfeasible or too risky, power is acceptable for the simple
reason that differences smaller than ten percent are not policy-relevant. In other words, if we
find that the resources CLA is investing in its current triage system are producing only minimal
(or no) gains to patient/victim mental and physical health, CLA will seriously consider changing
that triage system, as will (we believe) entities around the nation who are engaged in triage.
Thus, increases smaller than ten percentage points have the same policy relevance as a null
finding.

The previous paragraphs have focused on measurements associated with triage
protocols. As we mentioned above, however, our strong, randomized design will also allow us
to measure a second quantity of interest, the causal effect of obtaining a PO on protective
service reaccess, assuming (as we think likely) that patients/victims assigned an offer of CLA
representation are more likely to obtain POs than are those who receive no such offers. To obtain these estimates, our data analysis plan consists of deployment of principal stratification techniques (Frangakis & Rubin (2002), Greenland & Robins (1986), Robins (1986)), which are a generalization of popular and well-known instrumental variables or two stage least squares analysis outlined in any econometrics text (e.g., Wooldridge (5th ed. 2012)), to the half of the data subject to Triage Protocol Two. The idea here is that because the units in Triage Protocol Two are a random subset of all units, and because Protocol Two units are themselves randomized to an offer of full representation versus no such offer, we can view the Protocol Two units as having undergone their own, smaller, RCT. And in this smaller RCT, the randomly assigned instrumental variable, attorney representation, affects the intermediate variable, obtaining a PO. The research question is whether the intermediate outcome variable, obtaining a PO, affects the ultimate outcome of interest, protective service reaccess. Estimates of such an affect are available from principal stratification techniques (or, if one prefers to make some unverifiable assumptions, from instrumental variables techniques). Power calculations for this analysis are unreliable without knowledge of how well background variables predict the intermediate outcome variable (here, obtaining a PO), so we do not attempt them. The importance of such estimates is clear, however: as discussed above, the PO is the primary tool available to protect the mental and physical health of patients/victims, and protective service reaccess is the best available measurement of patient/victim health.

A word about scheduling: This study will take time, but the standard reasons to pursue an RCT instead of an observational study are particularly acute in the domestic violence context. Observational or case-control studies can be expected to work well when researchers understand the basic mechanisms involved in a data-generating process and have access to strong predictors of outcomes to include in modeling. But in the PO context, we believe that a great deal depends a victim/patient’s self-motivation, her ability to access non-legal support networks (that might help her navigate the system on her own), her desire to be free of her abuser, and a great many other factors that are difficult to measure. Observational studies can be expected to produce biased estimates in the PO setting because patients/victims who seek
and obtain legal assistance are probably dissimilar to patients/victims who do not do so, confounding results and rendering causal estimates suspect.

In short, our proposal is multidisciplinary. It deploys the strongest possible design for direct service provision, a randomized and anonymized field operation with objective outcome measurements. It deploys and assesses interventions and outcomes having the purpose of creating a culture and environment of health and communities free of violence. And it will directly assess the social and legal determinants of health.

WORK AND DISSEMINATION PLAN

Collaborations: We will be collaborating with our domestic violence shelter partners in our eight-county service area. Those agencies are: the Battered Women’s of Medina and Summit Counties, Christina House (serving Columbiana County); The Domestic Violence Project, Inc. (serving Stark County); Every Woman’s House (serving Wayne County); Family and Community Services (serving Trumbull and Portage Counties); (Sojourner House (serving Mahoning County). We will also be collaborating with Rape Crisis of Medina and Summit Counties; the Rape Crisis and Counseling Center (serving Mahoning County), the Rape Crisis program of the Stark County Chapter of the American Red Cross, the Mercy Medical Center SANE Unit (serving primarily Stark County), and St. Elizabeth Hospital’s SANE Unit (serving primarily Trumbull and Mahoning County).

Roles and Responsibilities of Key Personnel

Principal Investigator Marie B. Curry, Managing Attorney at Community Legal Aid, will lead the study in all activities that will take place in Ohio. These responsibilities include: maintaining and strengthening relationships with our collaborators; supervising all Legal Aid staff associated with the study, including attorneys, paralegals, and research assistants; and developing a pro se packet of materials to be used in provision of service Levels B and C. In addition, Curry will meet with court personnel, including judges, magistrates, and clerks, in the eight-county service area to explain the goals and design of the study and seek cooperation with the anticipated requests for court records to verify the terms of any POs granted and to
verify attempts by study participants to reaccess court assistance. Curry will also work closely with co-PI Greiner to develop data collection protocols and will monitor and ensure integrity in the implementation of data collection protocols.

Co-Principal Investigator Professor James Greiner will work closely with CLA and PI Curry refining the study design; developing data collection protocols; and training Legal Aid staff on implementation of the protocols. Greiner and his team will also review and offer revisions to improve content with regard readability and layout to the information packet of pro se materials to be provided to study participants who receive Levels B&C of services. Greiner will also conduct both randomizations, to ensure that CLA is, to the extent possible, blinded from this process. He will also lead the data analysis process and the plan for dissemination of the results.

**Major tasks and deliverables:** Please see timeline, below.

**Timeline**

**Six months prior to the start of funding:**
- Refine a standardized assessment tool in determining what level of service to provide;
- Update current counsel and advice tools, as well as our pro se materials;
- Complete process of normalizing intake across counties;
- Refine consent materials, obtain IRB approval from Harvard;
- Pilot the refined assessment and advice tools and refined triage protocol so as to be experienced in their application prior to the start of the study;
- Maintain and strengthen our existing relationships our DV shelter partners and with several rape crisis centers and SANE Units in our service area.
- Obtain final agreement from county courts regarding obtaining case files associated with PO petitions; and
- Meet with local law enforcement to share with them the study goals and request their cooperation when we present requests for police records pertaining to the study participants.
**First twelve months of funding:** enroll study participants; gather court records regarding disposition of petitions requesting POs; monitor compliance with all protocols.

**Final six months of funding:** continue activities of previous twelve months; collect data from courts and partner agencies; draft interim report of findings.

**For the subsequent eighteen months:** continue activities of previous year until desired enrollment is reached or enrollment protocol is adjusted based on interim findings; analyze all data; draft report with intent to publish results; disseminate results via publication, professional conferences, and other available avenues.

**Dissemination of results:** Professor Greiner will lead the process of composing one or more scholarly publications in peer review journals and law reviews detailing our findings. We anticipate intense interest from a variety of audiences: public health organizations and academics who are interested in creating communities and a culture of health, or in preventing violence against women and sexual assault; the U. S. Department of Justice, the court system in every state, and law enforcement officials who enforce and investigate violations of domestic violence and sexual assault laws; legal aid providers across the country, including umbrella organizations such as the Legal Services Corporation and the National Legal Aid and Defender Association (“NLADA”); and academics and agencies interested in the efficacy of triage protocols. Publications will be targeted accordingly. Professor Greiner’s track record is helpful on this score: He has published in peer-reviewed journals in statistics, economics, political science, and law. In addition to publication, the research team will disseminate the results at national and regional conferences. We will seek out opportunities at annual conferences of several organizations, including the NLADA and End Violence Against Women International (EVAWI), to present our research and findings in the form of learning sessions and poster sessions. We anticipate leveraging as many as four such opportunities in the last six months of the study, with additional opportunities likely to emerge with as data collection and analysis continues beyond the initial 18 months of funded research.

**IRB process:** Professor Greiner will obtain approval of the Harvard University Committee for Research on Human Subjects (“CRHS”). There is no fee associated with this process. The
CRHS has approved five prior studies Professor Greiner has conducted or is conducting involving randomization of legal services interventions. Each time, it has recognized that randomization in this context is ethical when there is a shortage of resources (the attorney time required for full representation) (Greely (1977)) and when there is equipoise as to efficacy of some intervention (Lilford & Jackson (1995)). As noted above, both shortage and equipoise are present here. In addition, Professor Greiner’s five previous studies provide ready consent form templates. Some of these studies involved highly sensitive asset information in divorce proceedings and closely guarded Social Security Administration data, so analogous consent language is available.

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**Triage Protocol 1:**
CLA Staff Assigns Level of Service

- **Level A:** Full Representation
- **Level B:** Telephone call; Packet
- **Level C:** Packet

**Triage Protocol 2:**
Randomizer Assigns Level of Service

- **Level A:** Full Representation
- **Level B:** Telephone call; Packet
- **Level C:** Packet