

## **ODVN Works to Enhance Community Domestic Violence Prevention Efforts**

The Ohio Domestic Violence Network (ODVN) has received funding from the Centers for Disease Control and Prevention to assist Ohio communities strengthen domestic violence prevention efforts. The DELTA (**D**omestic Violence Prevention **E**nhancements **L**eadership **T**hrough **A**lliances) Program goals are to:

**Stimulate the development and implementation of activities focused on domestic violence prevention. These activities must be integrated into coordinated community responses (CCRs). Furthermore, the DELTA program seeks to add a significant prevention focus to the existing CCR model by funding state domestic violence coalitions who will act as intermediary organizations in providing prevention focused technical assistance, training, and funding to local communities.**

Prevention efforts that are funded will work to:

- Reduce/eliminate the risk factors for the initiation of domestic violence and/or
- Enhance protective factors that could prevent domestic violence in at-risk populations and the community at large.

The ODVN DELTA Project has funded 6 Ohio counties and 4 domestic violence programs to **implement local prevention initiatives**, and to work in **collaboration with already existing local coordinated community responses**. Counties and programs funded in Ohio are:

- Belmont, Harrison, and Monroe Counties in collaboration with Women's Tri-County Help Center,
- Knox County in collaboration with New Directions,
- Lucas County in collaboration with Family and Child Abuse Prevention Center, and;
- Warren County in collaboration with Abuse and Rape Crisis Shelter

ODVN's DELTA Project will provide training and technical assistance any Ohio CCR. Training topics include "Domestic Violence Prevention and the Public Health Model," "Mobilizing Communities to End Domestic Violence," and "Working with Media to Impact Domestic Violence in Your Community." Contact: Rebecca Cline, DELTA Project Coordinator at 800/934-9840 or at [rebeccac@odvn.org](mailto:rebeccac@odvn.org).

## DELTA: What are we trying to prevent?

This document provides guidance for DELTA Project development and implementation as it defines the type of violence that will be the focus of the DELTA Project's activities and funding. It was developed collaboratively between the CDC and DELTA Cooperative Agreement Recipients. It does not represent an all encompassing definition of intimate partner violence, domestic violence, or any other type of violence, nor does it represent the official views of CDC regarding intimate partner violence.

1. DELTA has been classified as an intimate partner violence project at the CDC emphasizing intimate partner domestic violence (IP-DV). IP-DV is where one partner in an intimate relationship uses physical violence, sexual violence, threats of physical or sexual violence, psychological/emotional abuse, stalking and/or economic abuse to establish a pattern of coercive power and control over his/her intimate partner.
2. Intimate partners include current spouses, former spouses, current non-marital partners and former non-marital partners. Common-law spouses are included under the spouse term and first dates and long-term boyfriend and girlfriend relationships are included under the term non-marital partners. The intimate partners may not have cohabitated or had sexual relations. People with a child in common but who are not currently in a relationship are classified as intimate partners. Intimate partners may be of the same-sex or opposite sex. This definition of an intimate partner is derived from Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements (Saltzman, Fanslow, McMahon, & Shelley, 1999) published by the Centers for Disease Control and Prevention (CDC).
3. Research has consistently shown that men are more at risk for perpetrating IP-DV and women are more at risk for being victimized by IP-DV. Men represent close to 90% of state inmates serving time for IP-DV (BJS, Survey of Inmates in State Correctional Facilities, 1991). Each year three times as many women as men are *murdered* by an intimate partner (FBI, Supplemental Homicide Reports, 1976-1999). Women also experience five times as many IP-DV *assaults* as men (Department of Justice, Special Report NCJ 178247). From 1976-1999, the number of men murdered by an intimate partner dropped 69%, while the number of women murdered by an intimate partner dropped only 24% (FBI, Supplemental Homicide Reports, 1976-1999). In 1999, IP-DV accounted for 32% of all female murders, but only 3.6% of all male murders (FBI, Supplemental Homicide Reports, 1976-1999).
4. Generally intimate partnerships are considered to apply to adolescents and adults aged 14 and over. However, this age may be lowered depending on local circumstances.
5. There are risk factors at each level of the social ecology that contribute to IP-DV being perpetrated. At the individual level, risk factors include attitudes and beliefs, while at the family/partnership level, risk factors include attitudes, beliefs, structures and family/relationship norms. At the local community level and the larger societal level, risk factors include attitudes, beliefs, social norms, and institutional structures, policies, and procedures.

6. IP-DV knows no boundaries. It is not isolated to a particular class or racial, cultural or religious group. It can be found in any class or racial, cultural or religious group.

The DELTA Project is not trying to prevent domestic violence that might be classified as:

1. Child abuse
2. Due to organic brain disorders such as Alzheimer's disease
3. Elder abuse by caretakers, adult children or other non-intimates.
4. Violence initiated in self-defense
5. Violence initiated by drugs
6. One time violent incidents that are not supported by or result in a pattern of coercive control.

***This document does not represent the official views of CDC regarding intimate partner violence.***

## **The DELTA Program: Adding Prevention Enhancements from the Public Health Approach to the Coordinated Community Response Model**

CDC utilizes public health approaches to address intimate partner-domestic violence (IP-DV). Public health is a broad field that utilizes many principles, models and strategies to improve the health of the public. This document provides an overview of three public health concepts that inform CDC's Coordinated Community Response (CCR) program, the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Program. These three concepts are for whom the prevention activities are intended, when prevention activities occur, and at what levels of the social ecology prevention activities are needed. This document closes by providing more concrete examples of what type of 'prevention enhancements' can be supported through DELTA Program funding.

### 1. FOR WHOM the prevention activities are intended

Prevention of IP-DV focuses on preventing first-time perpetration and first time victimization. The group most at risk for perpetration of IP-DV is men, while the group most at risk of IP-DV victimization is women. At the societal level, risk factors for perpetration and victimization include historical and societal patterns that glorify violence against women, institutional structures that promote unequal power between men and women, and negative portrayal of women in the media. These risk factors require Universal approaches to address (see below). Individual risk factors require Selected approaches to address (see below). However, it is important to note that individual risk factors for perpetration are not the same as risk factors for victimization. Individual risk factors for victimization do not cause IP-DV, the responsibility for perpetration of IP-DV lies with the perpetrator. Some individual risk factors for male perpetration are gender-role conflict or belief in strict gender roles, homophobia, desire for power and control in relationships, and observing violence within the family of origin (O'Neil & Harway, 1999). Some risk factors for female victimization are low income (Rennison & Welchans, 2000), being under the age of 24 (Rennison & Welchans, 2000), and experiencing physical abuse as a child by an adult caretaker (Tjaden & Thoennes, 2000). Thus, activities focused at an individual level to prevent IP-DV perpetration are very likely to have a very different content and focus than activities focused at an individual level to prevent IP-DV victimization.

Whether focusing on preventing first-time perpetration or victimization, public health bases its activities and strategies on three types of groups for whom the activities and strategies are intended:

- UNIVERSAL approaches are aimed at everyone in an entire POPULATION regardless of each individual's risk for IP-DV perpetration or victimization. A population can be defined

geographically (e.g. an entire school, county) or by characteristics (e.g. ethnicity, age, gender).

- **SELECTED** approaches are aimed at those who are thought to have **HEIGHTENED RISK** for IP-DV perpetration or victimization. Using this approach is predicated on an understanding of what factors put people at higher risk for either perpetration or victimization and designing prevention activities to address these risk factors.
- **INDICATED** approaches are aimed at those who have already perpetrated IP-DV or those who have been victimized. These approaches work to lessen trauma among victims and increase accountability among perpetrators; however, some of these approaches may attempt to prevent a reoccurrence of violence.

Universal and selected approaches to the prevention of first-time IP-DV should have some aspects that focus separately on the prevention of first-time perpetration and preventing victimization, just as indicated approaches have some aspects that are separately focused at preventing a reoccurrence of perpetration and victimization (i.e., protective orders to prevent perpetration and support groups that allow victims to explore their options).

## 2. WHEN prevention activities occur

Public health divides prevention activities into 3 categories based on when the prevention activities occur in relation to the violence:

- **BEFORE** the IP-DV has occurred to prevent initial perpetration or victimization (sometimes referred to as **PRIMARY PREVENTION**)
- **IMMEDIATE RESPONSES** after the IP-DV has occurred to deal with the consequences of violence in the short-term (sometimes referred to as **SECONDARY PREVENTION**)
- **LONG-TERM REPONSES** after the IP-DV has occurred to deal with the lasting consequences of violence (sometimes called **TERTIARY PREVENTION**)

While the major purpose of activities that take place after violence has occurred is usually to prevent or ameliorate the negative effects of the violence, some of these approaches also attempt to prevent the reoccurrence of violence.

## 3. Integrating FOR WHOM and WHEN

In developing prevention activities for IP-DV, it is helpful to integrate **FOR WHOM** these activities are intended with **WHEN** prevention activities are offered. Figure 1 is a graphical representation of this integration. The cells in Figure 1 are not isolated, but actually overlap. For example, high school students could be defined as an entire population for a universal approach or as a high-risk group for a selected approach. Either approach could be appropriate, but which course

of action a community takes should be based on data and other considerations. Additionally, comprehensive community prevention strategies often systematically link activities from more than one cell together.

Figure 1

	<b>BEFORE (primary prevention)</b>	<b>IMMEDIATE RESPONSE (secondary prevention)</b>	<b>LONG TERM RESPONSE (tertiary prevention)</b>
<b>UNIVERSAL (everyone)</b>	Reduce risk in entire population by using approaches at each level of the social ecology that address the entire population	Increase public/community responses to intimate partner domestic violence that stimulate public action	Increase public/community responses to intimate partner domestic violence that stimulate public action
<b>SELECTED (high risk)</b>	Reduce risk of those at high risk by using approaches that address risk factors at each level of the social ecology		
<b>INDICATED (victims and perpetrators)</b>		Provide services to victims and perpetrators	Provide services to victims and perpetrators

Coordinated community responses (CCRs) have traditionally focused on the four darkened cells under the columns ‘IMMEDIATE RESPONSE’ and ‘LONG TERM RESPONSE.’ That is, they have traditionally provided criminal justice and victim services after violence has occurred to those victimized or those who have perpetrated IP-DV and have worked to increase public support for these responses. The DELTA Program’s goal is to support the integration of the two cells under the column BEFORE, activities designed to prevent IP-DV from initially occurring, into the coordinated community response model, such that CCRs are able to implement the full-spectrum of IP-DV prevention activities in their communities.

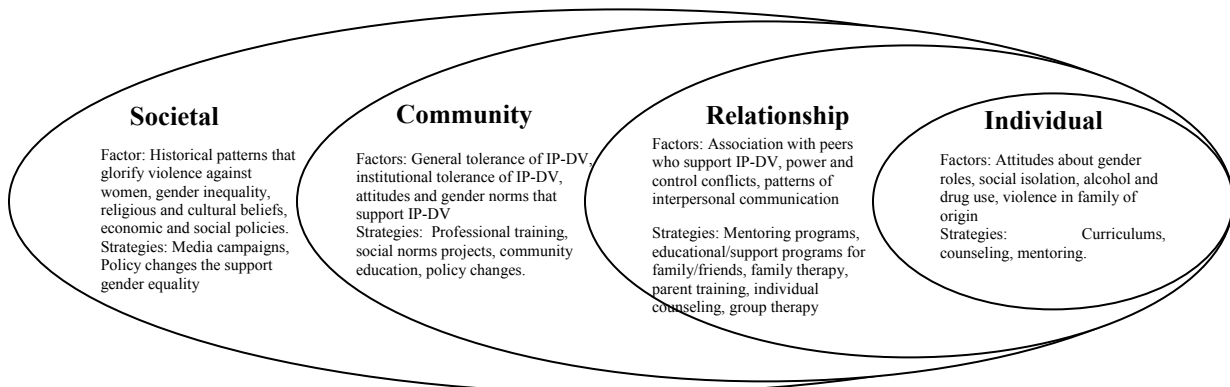
4. At what levels of the SOCIAL ECOLOGY are prevention activities needed

IP-DV does not occur in a vacuum. Factors at each level of the social ecology - individual, relationship, community and societal – contribute to the perpetration of IP-DV in our society. As factors at each level of the social ecology interact and reinforce each other, focusing on changing factors in one level of the social ecology will not lead to a significant reduction in the prevalence of IP-DV.

Integrated changes are required at each level of the social ecology. These changes are referred to as social change.

The model below notes some IP-DV risk factors at each level of the social ecology and different strategies that can be used at each level of the social ecology to support the type of social changes that will lead to a reduction in IP-DV. This model indicates that prevention of IP-DV, and the social change associated with this type of prevention, will require more than one project at one level of the social ecology in each community.

Figure 2 Social Ecological Model



- Individual level factors are biological or experiential factors that increase the likelihood of an individual becoming a victim or perpetrator of intimate partner domestic violence. For example, witnessing family violence as a child and alcohol use are risk factors for perpetration of IP-DV (Heise & Garcia-Moreno, 2002). Both men and women who experienced physical assault as a child by an adult caretaker are at increased risk for victimization (Tjaden & Thoennes, 2000). Activities for individual-level influences are often designed to affect an individual's social and cognitive skills and behavioral practices such as counseling, therapy, educational training sessions, and mentoring
- Relationship level factors are factors that increase risk as a result of relations with peers, intimate partners or family members. A person's closest social circle – peers, partners, and family members all have the potential to shape an individual's behavior or range of experience (Dahlberg & Krug, 2002). Activities that address relationship level influences that support IP-DV include family therapy and parenting training. However, family therapy should not be used once a pattern of power and control is developed or after violence has occurred within an intimate relationship. Family therapy is appropriate between a non-offending parent and children in order to help them cope with the after effects of violence by the offending parent. This type of family therapy is

best provided by a professional trained in trauma-based therapy and/or IP-DV issues.

- Community level factors are factors that increase risk based on community and social environments in which an individual has experiences and relationships such as school, workplaces, and neighborhoods. For examples, institutional structures and gender role socialization processes that promote unequal power between men and women are community risk factors. Interventions for community level factors are typically designed to improve that attitudes, skills and behaviors of those who work or serve in the community setting and to change the climate of tolerance in that setting.
- Societal level factors are larger, macro-level factors that influence domestic violence such as gender inequality, religious or cultural belief systems, and economic or social policies that create or sustain gaps and tensions between groups of people. For example, societal risk factors are historical and societal patterns that glorify violence against women and negative portrayals of women in the media. Interventions for societal level influences typically involve collaborations of multiple partners to increase awareness of the problem and to educate both the general public and policy makers.

Thus, the ecological model supports a comprehensive public health approach that not only addresses an individual's risk factors, but also the risk factors found in other levels of the social ecology.

## 5. Integrating WHEN, FOR WHOM and the SOCIAL ECOLOGY perspective

**Figure 3**

### **BEFORE the violence occurs**

**UNIVERSAL (Population)**

Individual	<ul style="list-style-type: none"><li>• Faith-based programs for all in the religion that attempt to change individual attitudes regarding violence in intimate partnerships</li></ul>
Relationship	<ul style="list-style-type: none"><li>• By-stander skill building activities that address relationship norms (e.g. changing normative beliefs that some intimate partner domestic violence is acceptable)</li></ul>
Community	<ul style="list-style-type: none"><li>• Training programs for "other influential/mentors" to change community and organizational norms that tolerate intimate partner domestic violence</li><li>• Develop, implement, and enforce organizational policies that support gender equality/equity</li></ul>
Societal	<ul style="list-style-type: none"><li>• Statewide, media campaign that addresses norms that support/tolerate intimate partner domestic violence</li><li>• Training for media professionals about how to add prevention messages to intimate partner domestic violence stories and reports. This would include information that supports removing messages that support violence against women in all media.</li></ul>

Figure 3 represents the square in the upper left-hand corner of the WHEN and FOR WHOM matrix (Figure 1). It outlines prevention activities intended for an entire population regardless of individual risk that can be provided to deal with IP-DV risk factors at each level of the social ecology to prevent IP-DV before it occurs.

## 6. DELTA Project Prevention Enhancements

As noted above, one goal of the DELTA Program is to support the integration of prevention activities designed to prevent IP-DV from initially occurring into the coordinated community response model, such that CCRs are able to implement the full-spectrum of IP-DV prevention activities. Therefore, the DELTA Program supports prevention activities for Universal and Selected (high-risk) groups prior to first time perpetration or victimization. For many CCRs, this will represent a significant change in their focus or mission. Recognizing the significance of this change to local communities, CDC looked for a program title that would symbolize this expansion in focus and mission. Therefore, CDC selected the term 'DELTA' as the DELTA symbol (  $\Delta$  ) means change.

Within the DELTA Program, activities designed or intended to prevent IP-DV are referred to as prevention enhancements and are defined as population based and/or environmental/system level services, policies and actions that prevent IP-DV from *initially* occurring and require a community level process to identify and implement. The DELTA Program focuses on preventing first time perpetration and first time victimization of IP-DV. The DELTA Program does not focus on providing intervention services such as law enforcement activities, victim/survivor services, or screening programs that may also have the advantageous affect of preventing future violence. Implementation and refinement of prevention enhancements will rely heavily on reciprocity between local CCRs, state domestic violence coalitions and CDC activities.

Prevention enhancements should take into consideration that there are risk factors at every level of the social ecology that contribute to IP-DV being perpetrated. Local CCRs are encouraged to consider multiple levels of prevention projects and activities. For instance, individual risk factors include attitudes and beliefs regarding violence and gender roles; while at the family/partnership level, risk factors include attitudes, beliefs, family structures and family/relationship norms. At the local community level and the larger societal level, risk factors include attitudes, beliefs, social norms, institutional structures, policies, and procedures.

Prevention enhancements should also take into consideration that IP-DV knows no boundaries. IP-DV is not isolated to a particular group or groups. It can be found in any age group, class, race culture, and religion. It is not isolated to one particular sexual orientation, nor does it discriminate on the basis of ability as those with a disability can also experience IP-DV.

For the purposes of the DELTA Program, prevention enhancements are defined into two broad categories based on where the prevention enhancement is initiated: CDC/State Domestic Violence Coalitions to Local CCR and Local CCR to State Domestic Violence Coalition/CDC.

**CDC/State Domestic Violence Coalitions to Local CCR Prevention Enhancements**

Local CCRs that receive DELTA Program funding will be expected to implement/participate in Prevention Enhancements collaboratively developed or identified by the CDC and the 14 DELTA State Domestic Violence Coalitions as defined as follows:

1. Initiatives – DELTA Program INITIATIVES are defined as replicable programs and events that focus on preventing IP-DV from initially occurring, and will have been proven effective through research or evaluation, or will be based on theoretically-sound principles. Generally, programs are considered to be long-term activities and have a specific content or curriculum associated with them. An example of a project would be the Safe Dates program implemented in a middle school (i.e. 10 session curriculum, poster contest and school play) or a Healthy Relationships program implemented within a faith community. Events are considered to be short-term or one-time events like a media campaign or the White Ribbon Campaign. For DELTA Program purposes, the CDC and the 14 DELTA State Domestic Violence Coalitions have identified 5 priority populations and 5 priority sectors and for each will identify programs and events that have been proven effective or are based on theoretically-sound principles. These populations and sectors are listed below. For each sector or population, at least one appropriate program or activity will be identified. For some sectors or populations, several appropriate activities or topics will be identified. **Local CCRs receiving DELTA Program funding are expected to commit to initiating one or more of these programs or activities in their local communities during the first year of funding.**

<b>Priority Populations</b>	<b>Priority Sectors</b>
1. Boys	1. Faith
2. Men	2. Education
3. Adolescents	3. Business
4. Communities of color	4. Healthcare/Mental Health
5. Girls	5. Neighborhoods
	6. Media

2. Skills – While the availability of programs and activities that have been proven effective is often useful to communities, communities often desire

to have the skills and knowledge necessary to adapt and develop prevention activities that will meet their own unique needs. Therefore, both state domestic violence coalitions and the CDC will provide prevention-focused skill-building and knowledge-building training and technical assistance to local CCRs. This training and technical assistance is not intended to replace 'practice-wisdom' but enhance the 'practice wisdom' found in each community.

- a. State domestic violence coalitions will provide the majority of this training and technical assistance through regional trainings, state conferences, and on-site trainings with local CCRs. This training and technical assistance is to occur throughout the duration of the DELTA Project. CCRs will rely mainly on the State Domestic Violence Coalitions for skill building training and technical assistance.
  - b. In the second half of 2004, the CDC will sponsor violence prevention training for DELTA Program state domestic violence coalitions and local CCRs that receive DELTA Program funding. This training will focus on providing the skills and knowledge needed to assess and design IP-DV prevention programs for local communities. It has not yet been determined whether this training will be a national or regional conference or some combination of distance learning with adjunct workshops. At this time, it is anticipated that in Fiscal Year 2004 CDC will be able to provide funding for several local CCR members from each funded CCR to attend this training (This is subject to change based on Congressional funding). Specifically, the training will focus on building the leadership, knowledge, and skills necessary for CCR members to plan, implement, and evaluate violence prevention programs using public health principles such as: evidence-based program planning (i.e., using data to drive program decisions); the ecological framework and other multi-level approaches to prevention; focusing on preventing the violence before it occurs; population-based strategies; program evaluation; and the feedback process for practice to research (i.e., using findings from the field to shape future research activities). This training is not intended to replace the training and technical assistance provided by state domestic violence coalitions, but supplement the training and technical assistance provided by state domestic violence coalitions.
3. Protocols – For years, profession-specific protocols designed to provide guidance on how to effectively intervene in IP-DV cases have been developed across the country. Most commonly, these protocols have focused on law enforcement, prosecution, courts, health care and battering intervention. DELTA Program protocol development will focus on identifying other professions and areas in which IP-DV prevention-oriented protocols may be relevant. Examples include developing prevention-

oriented protocols for professions and areas such as the faith community and the workplace. The development of these prevention-oriented protocols will require the input of both state domestic violence coalitions and CCRs that receive DELTA Program funding. Development of these protocols is not scheduled to start until mid-2004 after many state domestic violence coalition staff and local CCR representatives have attended the CDC-sponsored violence prevention training. It is believed that this training will provide a strong conceptual basis for thinking about professions and areas needing IP-DV prevention protocols.

### **Local CCR to State Domestic Violence Coalition/CDC Level Prevention Enhancements**

In addition to the National/State Level to Local Level Prevention Enhancements described above, local CCRs may develop their own prevention programming within certain parameters:

1. The development of prevention enhancements by local CCRs should not prohibit funded local CCRs from implementing/participating in the CDC/State Domestic Violence Coalition to Local CCR Prevention Enhancements listed above. The prevention enhancements developed by local CCRs cannot substitute for the implementation/participation in the CDC/State Domestic Violence Coalition to Local CCR Prevention Enhancements. Local CCRs will need to know the capacity of their community well-enough that they are certain their community can balance implementation/participation in CDC/State Domestic Violence Coalition to Local CCR Prevention Enhancements with the planning and implementation of their own prevention enhancements.
2. The RFA authorizing DELTA Program funding to state domestic violence coalitions noted that “the use of DELTA program funds for the development and production of new educational materials, media campaigns or curricula is prohibited without explicit approval” of the CDC. Local CCRs may develop their own prevention projects as long as such projects do not require use of DELTA Program funds for the development of new education materials, media campaigns, or curricula. The use and adaptation of existing prevention education materials, media campaigns, or curriculum is authorized.
3. CDC generally supports programs and events that are evidence-based or theory-based. Local CCRs are encouraged to propose their own prevention enhancements as long as these prevention enhancements focus on preventing IP-DV before it initially occurs and focuses on Universal or Selected populations within their community. Additionally, local CCRs would need to agree to work closely with their state domestic violence coalition to:
  - a. Identify risk factors being targeted for a Selected population (first year of funding)

- b. Provide rationale for Universal or Selected population chosen (first year of funding)
- c. Identify the conceptual/theoretical framework supporting the local prevention enhancement or the evidence-based program on which the prevention enhancement is based (first year of funding)
- d. Develop an evaluation plan for the local prevention enhancement (first year of funding)
- e. Implement and complete the evaluation plan throughout the program period (three years).
- f. Provide the state domestic violence coalition with a final evaluation report (last year of funding)

Additionally, as CDC is greatly interested in learning from local CCRs about their prevention efforts, local CCRs will be expected to share their experiences with the state domestic violence coalition within their state so that lessons learned from these prevention efforts can be shared within their state and across the country with the other 13 DELTA Program state domestic violence coalitions and the CDC.

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