Moving Upstream

Virginia's Newsletter for the Primary Prevention of Sexual & Intimate Partner Violence

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Delving Into "Evidence-Based Prevention"

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This issue of *Moving Upstream* addresses evidence, or more plainly, how we can use what we've learned from past prevention efforts to inform subsequent prevention efforts, maximizing the chance that our programs will reach desired outcomes. The last issue of *Moving Upstream* examined the importance of basing prevention programs on a logical rationale (such as established theories) for this same purpose.

Wendi Siebold's article explores several dimensions of "evidence" in the context of primary sexual & intimate partner violence (SV/IPV) prevention. She also provides helpful suggestions for how the SV/IPV prevention field can systematically build a larger base of evidence for strategies seeking to end first-time perpetration of SV/IPV.

My interview with Taryn Lindhorst and Emiko Tajima delves into an issue at the core of any attempt to assess programmatic outcomes: Defining and measuring the key construct(s) that will ultimately tell us if our prevention efforts are working (and if so, how well they are working). In the case of primary IPV prevention, the prevalence and incidence of IPV is perhaps the most crucial construct to measure. However, defining IPV for the purposes of program assessment or research has been difficult thus far. At present, the most commonly used measurement tools for IPV tend to oversimplify it as little more than individualized aggressive/violent behaviors. Such a definition of IPV is inadequate because it does not match the complex reality of IPV shown to us by years of research and victim testimony. Lindhorst and Tajima discuss the shortcomings of the current measures of IPV, as well as how to develop measures that more fully (and accurately) capture the multi-layered nature of IPV.

Finally, I want to remind everyone that Virginia's *Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence* are finished and available for download! The *Guidelines* are a product of a partnership between VSDVAA and the Virginia Department of Health, and are meant to assist local sexual and domestic violence agencies in developing effective primary prevention initiatives. Download it at: http://www.vsdvalliance.org/whatsnew.html.

Showing Our (Prevention) Work: *Evidence-informed decision-making*

Wendi Siebold, MA, MPH, Senior Research Associate
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It's official. The word "evidence" has finally landed in the fields of SV/IPV prevention. Yet, what does 'becoming more evidence-based' really mean? And where does this leave practitioners? The idea of using evidence in prevention often conjures up images of research studies that may or may not be accessible or relevant to practitioners. In this article, we're going to take a closer look at the ways in which prevention practitioners can contribute to our "evidence base" and our understanding of what works to prevent IPV and SV.

First, let's clear up some of the confusing terminology. It is important to distinguish between two terms when talking about "evidence:" Evidence-based programs and evidence-informed decision-making. "Evidence-based programs" are grounded in theory and have been rigorously evaluated to show at least *some* positive outcomes.

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Inside this issue:

Funder's Forum

2010 RPE Grant Proposals / *Safe Dates* Trainings

Rebecca Odor, MSW, Director of Sexual & Domestic Violence Prevention
Division for Injury and Violence Prevention, VDH

In 2010, Virginia Department of Health/Division of Injury and Violence Prevention (DIVP) anticipates releasing a Request For Proposals (RFP) for sexual violence primary prevention projects. The RFP will request that Virginia Sexual Violence Advocacy Agencies that are interested in providing primary prevention projects submit a competitive proposal to be considered for funding. DIVP expects to issue the RFP in the spring/early summer for contracts that will have a starting date of November 1, 2010. It is also anticipated that the RFP will reflect the concepts that are delineated in the "Guidelines for the Primary Prevention of Sexual Violence and Intimate Partner Violence" which was recently published by the Virginia Sexual and Domestic Violence Action Alliance.

Each year, DIVP hosts an Annual Meeting for the contractors who have received funding for sexual violence primary prevention projects. However, for the next Annual Meeting, DIVP would like to invite any Sexual Violence Advocacy Agency that is considering submitting a proposal in response to the 2010 RFP to participate in the second day of the meeting. A majority of that day will focus on the upcoming RFP. While the RFP will not be completed at that time, it will give agency staff an opportunity to learn about what DIVP anticipates will be included in the RFP. In addition to reviewing the "Guidelines" that are noted above, there will be discussion of the Virginia strategic plan for sexual violence prevention. This meeting will allow agency staff to have information that will hopefully assist them as they prepare to submit a high quality proposal for the primary prevention of sexual violence.

All Sexual Violence Advocacy Agencies are welcome to attend the Annual Meeting on Friday, January 8, 2010, from 9:00 to 3:00. The meeting will be held at the Albemarle County Office Building, (Room A) at 1600 5th Street, Charlottesville, VA. Please notify Jayne Flowers at jayne.flowers@vdh.virginia.gov if you plan to attend to the meeting. She will need your name, email address, phone number, and the name of the agency you represent.

Attend a Full Day Training on Safe Dates

Safe Dates is the only evidence-based curriculum that addresses teen dating violence. Attend this full day training to be able to facilitate the curriculum with youth. The training will provide an overview of the issue, demonstration of curriculum materials and opportunities for participants to practice teaching the materials. These are the dates and locations:

December 4th in Christiansburg, VA // December 7th in Chesterfield, VA // December 15th in Staunton, ,VA

There are different ways to attend this training. If you do not currently own the Safe Dates materials: 1) You may pay a $161 registration fee by credit card and you will receive a copy of the curriculum at the training. -OR- 2) You may order the curriculum directly from Hazelden, and then register at the "training only" rate, which is at no cost to you.

The true cost of this training per participant is about $54, plus the cost of program materials. Each set of Safe Dates is valued at $215. The cost of this event is covered by federal funding from the Centers for Disease Control and Prevention. For more information on the Safe Dates curriculum, go to Hazelden (www.hazelden.org). To register, go to www.vahealth.org/injury/sexualviolence. For more information on the training, contact Rebecca Odor: 804-864-7740.

Evidence-informed decision-making (from Page 1)

Now consider the term "evidence-informed decision-making." Evidence-informed decision-making, or using evidence to make decisions when doing prevention work, involves multiple types of evidence - one of which is the more traditional research-based evidence that can come from the aforementioned evidence-based programs. Other types of evidence include those that more directly rely on the involvement of practitioners to document the implementation and outcomes of their prevention strategies. Figure 1 on page 4 shows the complementary way in which various types of evidence combine to create evidence-informed decision-making. It's the combination of these various types of evidence that will help you be more informed when making decisions about planning and implementing prevention programming. "Evidence-informed decision-making" is a more inclusive way of incorporating community-based knowledge and practice into discussions about, and the collection and use of, evidence.

"The Lists"

For the past ten years or so, many fields of prevention have focused on funding and testing programs to determine if they are "evidence-based" or "promising" or "model", etc. These classifications are the result of programs being rigorously evaluated and shown to be effective at changing their intended outcomes – some more consistently than others. Most IPV and SV prevention programs would not make these lists, although some would likely fall in the "promising" category: They are theory-based and have achieved some positive results,

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Evidence-informed decision-making (from Page 2)

but maybe not consistently. This process of categorization started in substance abuse prevention, and has moved into HIV prevention, youth violence prevention, and other areas of public health. There are now multiple "lists" available, and most federal agencies have developed their own list of evidence-based prevention programs. Our field does not have a definitive list of effective programs for IPV or SV prevention, and that may not be a bad thing. Across various social and health issues, the public health community is starting to recognize that we *have* to be more comprehensive in the way we think about evidence. It is the combination of research-tested model programs *and* evidence-informed programs grounded in community approaches that will lead us down a path of comprehensive, effective prevention efforts.

Take a moment to think about the prevention activities and programs that you've implemented in your community. Which ones would you consider "evidence-based"? Is it more accurate to describe these as "promising"? Which sexual violence or intimate partner violence prevention programs do you consider "promising"?

Moving Beyond "The Lists:" What *You* Can Do

So how can practitioners move beyond these lists to be more evidence-informed in their prevention practice? The main way to start building our own evidence base and becoming more evidence-informed is to engage in discussions about the way we are doing prevention. Follow Na-

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"'Evidence-informed decision-making' is a more inclusive way of incorporating community-based knowledge and practice into discussions about, and the collection and use of, evidence."

Promising Practices

Battering & Beyond: Making the case for fuller & more valid measures of IPV

Taryn Lindhorst & Emiko Tajima, Faculty Members
The School of Social Work, University of Washington in Seattle, WA

The following interview was conducted by Brad Perry with Taryn Lindhorst and Emiko Tajima via email in the second week of October, 2009.

1) What are the limitations of behaviorally focused measures of IPV?

As more people have become familiar with IPV, researchers have been more inclined to insert simple behavioral counts of IPV into surveys on a variety of factors. Unfortunately, to only count behaviors, particularly physical ones (e.g., punching, slapping, pushing, etc.), is to miss many of the dimensions that we have learned are a part of the experience of IPV. For example, many survivors of IPV report that physical attacks were not as frequent as attempts on the abuser's part to control the survivor through the use of threats, intimidation and punishment that couldn't be seen, such as threatening to harm family members, pets or treasured objects, or by cutting the survivor off from financial and personal resources. By asking primarily about physical events, some of the more common experiences of survivors of IPV remain unrecognized, and the prevalence of IPV is underestimated.

2) In your experience, how do those without a background in research or IPV victim advocacy typically make sense of IPV measures that only count behaviors? Do you think they understand the limitations of this data?

One of the reasons we were motivated to write about the need to put the measurement of IPV into a larger set of contexts was the fact that people without a research background or researchers who don't know much about IPV tend to take behavioral counts at face value, as if all forms of IPV are of equal weight. In other words, that a "hit is a hit" no matter the context. It is interesting that people tend to view physical IPV in this detached manner given that, in other settings, we are concerned about how and why something happened. For example, if one person hits another and the second person hits back, we would consider that the second person has acted in self-defense after being attacked by the first. In surveys that only count behaviors, we have no way of sorting out such contextual reasons for what is happening, which enables researchers (and anyone reading the research through this overly simplified lens) to treat one person attacking and another person defending as equivalent behaviors.

3) You use the term "contextual factors" to describe the forces that both shape what behaviors are defined as IPV, and influence the ways survivors respond to victimization, the resources available to them, and the environments in which they cope with abuse. What are the specific examples of contextual factors that you'd like to see incorporated into IPV survey research?

There are a number of contextual factors that matter when measuring IPV. The ones we've focused on thus far are the situational con-

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Evidence-informed decision-making (from Page 3)

tion, et al's (2003) prevention principles, or Virginia's guidelines for the primary prevention of SV/IPV. Start evaluating your prevention activities, strategies and programs. Start documenting your work in a way that will help inform both you and the movement about the most promising ways to prevent SV/IPV. Prevention practitioners have a long history of "making programs up as we go." As we start to plan and evaluate our prevention programming in a more strategic manner, our own promising programs will emerge and we'll start to see overlap between and among our prevention efforts. Below are some specific ways to start becoming more "evidence-informed" in your prevention work:

Follow the Prevention Principles

By now, you are no stranger to the "nine principles of effective prevention." Grab a copy of the Action Alliance's new "Guidelines for the Primary Prevention of Sexual Violence and Intimate Partner Violence" to get started with a translation of these principles that is more specific to our field. It's important to remember that the prevention principles are a big picture discussion, because they relate to how you plan your entire "portfolio" or collection of prevention programming. Even if you are implementing a "promising" or "model" program, you should still try to follow these principles. For example, implementing healthy relationship curricula with high school students is great, but what else is being done to ensure that they receive the same messages in a comprehensive manner? What is being done with the school staff, parents, and the larger community to support the norms and behaviors you are trying to change with the healthy relationships curricula?

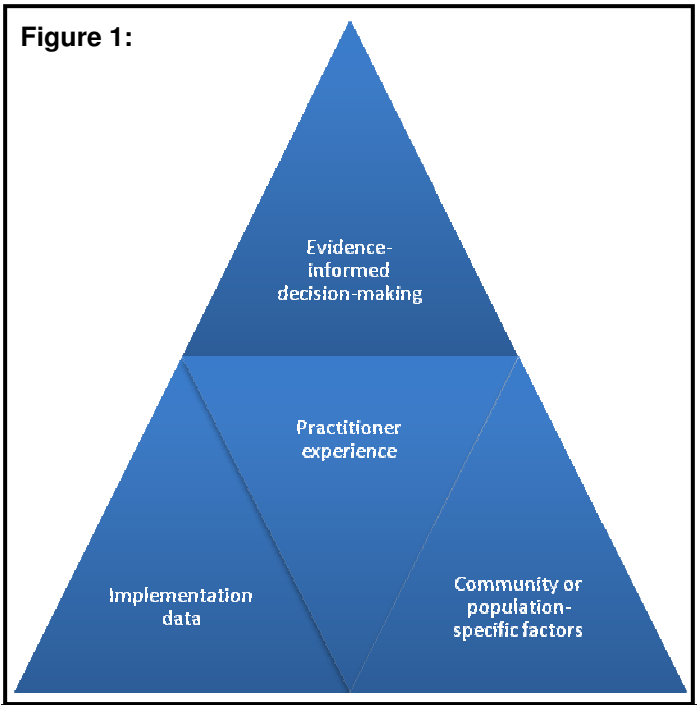
Know How Each of Your Prevention Activities Is Being Implemented

There are terrific resources available to help you get started with evaluation. Both adapting a program and developing your own program require that you understand *how* you have implemented the program or activity. This is process evaluation. Process evaluation is the starting point for understanding what you are implementing. Only when you have the resources to do a process evaluation that is useful and feasible, should you take the next step of doing an outcome evaluation. The combination of process and outcome evaluation findings will help you identify core elements of your programming that are responsible for change, and identify areas to make improvements to bring about that change.

Try to answer these questions about your prevention activities: How are you tracking the implementation of your programming? Do you write down how many people attended each session? What content was covered or not? Do you measure participant satisfaction? Do you keep a list of who facilitated what sessions or activities? Just knowing *how* your program was implemented is the foundation on which a quality outcome evaluation is based.

Program evaluation can help practitioners document what seems to be working within specific local settings or populations. This is often the missing piece when research-tested programs are used in communities outside of the ones in which they were initially developed. Remember, you are the *key* to documenting evidence about the implementation of a given prevention strategy in *your* local community . We need to move from having "common knowledge" to documenting "what works." What seems like common sense to you will need to be documented so that your peers in prevention can implement the program. The VAW movement has been sharing best practices among practitioners for years; now we're just becoming more formalized.

Figure 1:



Foundation of Evidence-informed decision-making.

Find Commonalities With Other Prevention Programs That Are "Evidence-Based"

The more we distill what the primary prevention of SV/IPV looks like, the more we see the potential overlap of risk and protective factors related to other social and health problems. Take HIV prevention and sexual violence prevention for example. Some risk and protective factors may be unique to each issue. However, the behavior change techniques, such as bystander intervention, social

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Evidence-informed decision-making (from Page 4)

norms campaigns, and popular opinion leader approaches, address many of the same risk and protective factors that we target for sexual violence prevention. Although research on the risk and protective factors for IPV and SV perpetration is still limited, they appear to share many of the same risk and protective factors as several other related health and social behaviors. We might be able to benefit from the "lessons learned" in more well-resourced fields such as HIV prevention, and begin to understand how we can apply their promising practices to our own approaches.

Build Relationships With Prevention Practitioners In Other Fields

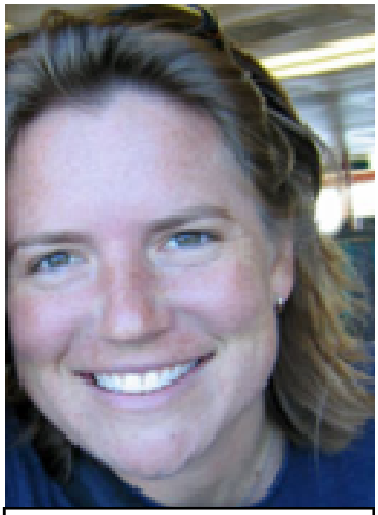
Our relationships with stakeholders in various communities are key to doing prevention. Identifying what our field has in common with other prevention fields helps us bolster such relationships with existing partners. Being able to discuss our work in the context of how it is similar or unique to the work with which potential partners are already familiar, we can meet on common ground and use prevention resources more wisely. Remember, SV and IPV are complex problems that require multiple levels of prevention efforts within a community. We can't do this alone.

Think about how you "frame" your prevention efforts. Do you call it rape prevention, or do you call it something else? Have you found ways to identify specific parts of your programming that address common factors found in *other* prevention programs, such as youth violence and substance abuse prevention? Primary prevention happens at a time when a lot of social and health factors may have similar consequences on a person's life. For example, growing up in a violent culture may promote violent behaviors associated with bullying, gang violence, domestic violence, *and* sexual violence. Prevention efforts focusing on any of these behaviors most likely include similar program components and activities. If we find and name our similarities with other prevention fields, we may be able to implement more comprehensive and complimentary prevention practices.

Partner With Those Who Have The Resources To Rigorously Evaluate Your Efforts

Any practitioner should be able to track her or his program implementation by doing a basic process evaluation. This is essential to using your prevention resources wisely and improving what you implement. As you acquire more resources, you can start doing more rigorous evaluation activities, including outcome evaluation. However, you may also be ready to partner with a researcher who can design a more rigorous outcome evaluation of your program, which will help show whether your prevention program is truly meeting its intended outcomes.

"As we start to plan and evaluate our prevention programming in a more strategic manner, our own promising programs will emerge and we'll start to see overlap between and among our prevention efforts."



Wendi Siebold, MA, MPH

Various research approaches, such as community-based participatory research, attempt to incorporate a community's voices during the development and implementation of the program. However, the resources to sustain the program in the way it was originally developed and tested usually disappear once the research funding is gone. A more sustainable way of collaborating with research partners is to hire them as evaluators of your program, so that *your* program funding is not dependent on *their* research funding.

We Can Do This!

As a field, we often feel behind in discussions about "evidence" compared to other prevention fields. However, we are ahead in many ways. Researchers in well-funded prevention fields are now realizing the importance of practitioner-generated evidence to help inform "what works" in a variety of settings and populations. We can benefit from the numerous promising grassroots SV/IPV prevention activities our communities have been developing for decades. Now practitioners and researchers can work together to begin identifying how to build our own "evidence base." Good luck with your evidence-informed decision-making!

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Making the case for fuller and more valid measures of IPV (from Page 3)

text, cultural context, historical context, and what we describe as the context of societal oppression. We also argue that it is important to measure the victim's interpretation of a given experience.

Researchers are developing tools to assess a range of situational factors, like who usually starts a physical altercation and whether an injury results. Others have created measures that try to expand beyond physical violence and capture the emotional experience of victimization, particularly the level of fear and intimidation that might occur. The Women's Experience of Battering is a good example of this kind of measure.

Understanding context is important for determining when we think IPV has occurred, and also for identifying the ways survivors respond. For example, the consequences and meaning of a given act may differ for different groups. In one study, adolescents who reported that their partner had hit them were asked how they felt about that experience – boys were more likely to laugh about it or ignore it, while girls were more likely to cry or fight back. These discrepancies in consequences show us that boys and girls have significantly different reactions to being hit by their partners – and in fact, what many of the boys described was not IPV at all.

If we want to understand differences in how survivors cope with IPV, we also need to know about the social context and its effects. Survivors' different cultural contexts influence their responses to IPV. For instance, immigrants to this country may have more difficulty finding resources to address IPV because of language and legal barriers. Another example is that most states do not recognize lesbian, gay, bisexual or transgender (LGBT) relationships, so getting access to resources that are knowledgeable about LGBT lives may be difficult. Both these brief examples illustrate that without knowledge of contextual factors, we may have little understanding of the differences in psychosocial outcomes for people who experience the same behavior (i.e., being hit).

4) You've articulated a number of specific strategies for including these contextual factors into the survey measurement of IPV. Please briefly describe a few of these strategies.

We think that people who are conducting research can benefit from the following ideas about ways to measure the context of IPV experiences:

- Assess the situational context, specifically the motivations for (e.g., self-defense, control and coercion) and adverse effects (injury, emotional impact, responses) of violence and relationship power dynamics (history of power and control, history of battering).
- Incorporate questions that directly measure survivor's perceptions of the degree of abusiveness of each act (perceived severity, perceived impact).
- Identify culturally specific acts that are considered abusive to survivors within their own culture.
- Identify relevant aspects of culture for each group or sub-group and assess these, including (but not limited to) acculturation/enculturation; ethnic identity; attachment to culture; migration experiences, generational status; and cultural beliefs, norms, attitudes, and traditions.

5) What is the ultimate benefit of incorporating contextual factors into IPV survey research?

The context surrounding behaviors associated with IPV matters for a number of reasons. One of the issues of concern to researchers is the question of validity – do our measures reflect an accurate understanding of the phenomenon? When we incorporate contextual measures, prevalence rates for IPV change. When we don't measure contextual factors, we only see part of the picture. To better understand IPV, its prevalence, impact, and how to respond to it, we need to see this fuller picture. The context of IPV can explain the variation in responses of battered women to the violence they experience - and it is fundamental to understanding the motivation for violence. And the social significance of IPV, such as the response of others like the police, is often dependent on its social contexts. To better help survivors, and ultimately prevent violence in intimate relationships, we need the most accurate and complete understanding of these events possible.

Taryn Lindhorst

"One of the issues of concern to researchers is the question of validity….When we incorporate contextual measures, prevalence rates for IPV change. When we don't measure contextual factors, we only see part of the picture."

Emiko Tajima