# North Dakota
# Intimate Partner & Sexual Violence Prevention Plan

***Working together to create a community free of intimate partner and sexual violence in North Dakota.***

*~ Mission Statement*

*Bully Pulpit Golf Course – Medora, ND*

**Sponsored by:**

ND Council on Abused Women's Services/ Coalition Against Sexual Assault in ND

ND Department of Health Division of Injury Prevention and Control

This plan was made possible through the cooperative agreements with the Centers for Disease Control and Prevention and the ND Department of Health: U17/CE824955-03 (EMPOWER); 5VF1/CE001113-02-2 (RPE); and the ND Council on Abused Women's Services/Coalition Against Sexual Assault in ND: US4/CE822581-06 (DELTA).

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State of
North Dakota
*Office of the Governor*

John Hoeven
*Governor*

April 23, 2009

Dear Community Members, Policy Makers and Advocates,

Domestic violence and sexual assault pose serious public health risks to North Dakota residents. In 2008 alone, more than 4,500 domestic violence and nearly 900 sexual assault victims sought services from crisis centers statewide. While it is critical to have services available for victims, it is also important to increase the public understanding of these issues and remain committed to prevention of any and all violence.

For the past thirty years, crisis centers and communities have been focused on improving the criminal justice system response, increasing public awareness, and enhancing services to victims of domestic violence and sexual assault. Their efforts have proven successful, but there is more to do. Primary prevention is the next stage in the work to end domestic violence and sexual assault.

Since early 2006, stakeholders from across North Dakota have worked collaboratively to create a plan to prevent domestic and sexual violence. This plan will provide advocates and communities with strategies to improve North Dakota's efforts to prevent violence.

Thank you to the Intimate Partner and Sexual Violence State Prevention Team and others who put the time into writing this important plan. I encourage everyone to join efforts to prevent domestic violence and sexual assault in North Dakota.

Sincerely,

John Hoeven
Governor

38:63:59

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NORTH DAKOTA
DEPARTMENT *of* HEALTH

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June, 2009

Fellow North Dakotans:

Intimate Partner Violence and Sexual Violence are a significant public health concern in North Dakota. In 2008, 4,258 new victims of intimate partner violence received services from crisis intervention centers in North Dakota. In the same year, 854 primary victims of sexual assault also sought out crisis services. In a response to these issues, the State Intimate Partner and Sexual Violence Prevention Team has put together a state plan for prevention.

This plan was developed through a partnership with the North Dakota Council on Abused Women's Services/Coalition Against Sexual Assault in North Dakota, the North Dakota Department of Health's Division of Injury Prevention and Control and the University Of North Dakota's Center for Rural Health. These partners, together with stakeholders from a multidisciplinary background across the state, came together to create a plan that is grounded in primary prevention.

This plan serves as a guide for state and local leaders as we continue to improve our efforts in prevention of intimate partner and sexual violence. I hope you will join with partners across the state in addressing this important problem of preventing violence.

Sincerely,

Terry L. Dwelle, MD, MPHTM, CPH
State Health Officer

TLD/DR:lrr

Phone: 701.328.2372 Fax: 701.328.4727

# FORWARD

Fellow North Dakotans:

The North Dakota Council on Abused Women's Services/Coalition against Sexual Assault, in partnership with the North Dakota Department of Health, Division of Injury Prevention and Control and the North Dakota Intimate Partner Violence and Sexual Violence State Prevention Team, are pleased to present the Intimate Partner and Sexual Violence Prevention Plan. This plan provides North Dakota with a comprehensive framework to prevent first time incidents of intimate partner and sexual violence by targeting leadership, data, and evidence based programming. By targeting these three areas, it is our mission that we can begin to work together to create communities free of intimate partner and sexual violence.

Intimate partner violence and sexual violence affects every one of us. In a recent survey administered to North Dakotans, nearly 70% of respondents acknowledged that sexual violence was occurring in their community and 61% agreed that it was possible to prevent it. Prevention is possible. Most North Dakotans agree.

North Dakota has been a model for the infusion of intimate partner violence prevention with sexual violence prevention through combining the work of three programs: Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA), Enhancing and Making Programs and Outcomes Work to End Rape (EMPOWER), and Rape Prevention Education (RPE). The blending of these three programs has proven vital for maximizing resources, especially in a rural state. The multifaceted nature of these projects – at the local, state and national levels – requires not only knowledge and commitment, but equally importantly, a vision to lead the movement to prevent intimate partner and sexual violence.

We would like to thank the individuals and organizations who dedicated their time and expertise to developing the plan. But we are only just beginning. We invite you to become involved in helping us implement the plan. It will take all of us working together to accomplish our vision of one day ending intimate partner and sexual violence.

Janelle Moos
Executive Director
ND Council on Abused Women's Services/
Coalition Against Sexual Assault in ND

## *ACKNOWLEDGEMENTS*

***The following members of the North Dakota Intimate Partner and Sexual Violence State Prevention Team (SPT) assisted in the development, review, and finalization of the State Prevention Plan. Their input and insight is greatly appreciated.***

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Celeste Barfield, Minot Air Force Base
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Diana Read*

University of North Dakota – Center for Rural Health: Empowerment Evaluation Team
Pat Conway, Jennifer Wages, Marlene Miller, Naomi Peyerl

**Indicates current members of the SPT*

# CHAPTER ONE: INTRODUCTION

***Violence is not an insurmountable problem.***
***It can be prevented using a thoughtful and systematic approach.***

Dr. Rodney Hammond
Director, Division of Violence Prevention
U. S. Centers for Disease Control and Prevention (CDC)

Intimate partner violence (IPV) and sexual violence (SV) harm North Dakotans, their families, their communities, the organizations in which they work, and taxpayers. Preventing IPV and SV would eliminate this harm, reducing the costs associated with it. Individuals who experience violence find their lives irrevocably changed. Marcia Thompson, a 21 year old college student, was in her kitchen talking on the phone with her boyfriend. Sam Wozniak, her 33 year old neighbor and a doctoral student at the same university that Marcia attended, broke through the door and sexually assaulted her. Marcia's boyfriend and the police arrived at the same time; Sam was arrested. A year later, Marcia visited the local rape crisis center seeking solace. She had terminated her relationship with her boyfriend, due to overwhelming and complex feelings related to the rape and events surrounding it. Marcia was unable to sleep. She had dropped out of college. At this juncture, Marcia decided to seek intervention because her thoughts of suicide were frightening her. This episode changed the lives of everyone connected with Marcia, Sam, the police department, and the rape crisis center.

How often does intimate partner violence and sexual violence occur? In North Dakota (ND) in 2009, domestic violence and rape crisis (DV/RC) agencies provided services to more than 900 sexual assault victims and more than 4,500 domestic violence victims; numbers that have remained consistent over the past 10 years North Dakota Council on Abused Women's Services/Coalition Against Sexual Assault in North Dakota (NDCAWS/CASAND).

> Intimate partner violence (IPV) is a serious, preventable public health problem affecting more than 32 million Americans (Tjaden and Thoennes, 2000). Additionally, results from the National Violence Against Women Survey (NVAWS) revealed that 17.7 million women and 2.8 million men in the United States were forcibly raped at some time in their lives (Tjaden and Thoennes, 2006).
>
> *Tjaden and Thoennes, 2000/2006*

What are DELTA, EMPOWER and RPE? In North Dakota, Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA), Enhancing and Making Programs and Outcomes Work to End Rape (EMPOWER) and Rape Prevention and Education (RPE) are primary prevention, capacity building programs for IPV (DELTA) and SV (EMPOWER/RPE).

NDCAWS/CASAND received funding from CDC in January 2003 and has worked collaboratively with six local domestic violence/rape crisis (DV/RC) agencies and their community task forces to prevent IPV.

> The DELTA Program is a collaborative agreement whose purpose is to add a significant prevention focus to the existing Community Coordinated Response (CCR) model by funding state domestic violence coalitions who will act as intermediary organizations by providing

prevention-focused training and technical assistance and funding to local communities. North Dakota is one of the fourteen State Domestic Violence Coalitions funded through DELTA.

*CDC website*

EMPOWER funding was awarded to the ND Department of Health (NDDoH) in August 2005 to build the department's capacity to administer the RPE grant to focus on primary prevention of sexual violence.

The EMPOWER program is a planning, implementation, evaluation, and sustainability capacity building cooperative agreement. Centers for Disease Control and Prevention (CDC) works intensively with EMPOWER states within a collaborative learning environment to build the individual capacity of EMPOWER State Capacity Building Teams (SCBT).

*Karen Lang- CDC*

RPE funding began with funds provided to the NDDoH through the Preventative Health and Health Services Block Grant funds earmarked for Rape Crisis and Prevention Services during the 1981-83 Biennium. Administration of the RPE program changed within CDC in 2002. In 2005, these funds were re-defined and structured in ND exclusively for primary prevention planning.

The Rape Prevention and Education (RPE) program provides opportunities for state and local agencies to address sexual violence as a preventable community problem. RPE funds provide critical support to communities and states as they work toward a future free of sexual violence.

*Kristen Houser*
*National Alliance to End Sexual Violence*

## THE DEVELOPMENT OF INTIMATE PARTNER AND SEXUAL VIOLENCE PREVENTION CAPACITY IN NORTH DAKOTA

### *Overview*

For the past thirty years, crisis centers and communities have been focused on improving the criminal justice system response, increasing public awareness, and enhancing services to victims of domestic violence and sexual assault. The history of domestic violence intervention services in North Dakota and nationally are deeply rooted in advocacy, including individual case advocacy for victims experiencing violence and systems advocacy or advocating for public policy changes and improvements to the criminal justice response. Similarly, the anti-rape movement of the 1970's was led by survivors and rape crisis centers focused on establishing 24 hour crisis lines, conducting prevention education and training programs, offering self defense classes and "Take Back the Night" events, and individual advocacy helping victims heal from rape (Poskin, 2006). Ultimately, the goal of both the domestic violence and anti-rape movement was social change. With the passage of the Violence Against Women Act (VAWA) in 1994, the

RPE program was established pushing crisis centers to focus on prevention as well as intervention (Poskin, 2006). This program in addition to the DELTA and EMPOWER programs allows communities and states to refocus on social change that include promoting male responsibility for stopping rape and domestic violence and undoing attitudes and associated behaviors that allow the sexual exploitation of women and girls (Poskin, 2006). Prevention activities began in ND in the mid-1980's as communities began to move beyond promoting awareness to providing education to schools and professionals. Prevention activities focused on providing informational sessions to children and adults regarding the warning signs of abuse and educating about the resources available to victims.

Originally, beginning in 1994, RPE funds came to ND from the Preventive Health and Health Services Block Grant through the U. S. Department of Health and Human Services and since 2002 from the Centers for Disease Control. These funds are administered by the NDDoH. Funds are distributed to DV/RC agencies and NDCAWS/CASAND. DV/RC agencies historically used the RPE funds to provide one time informational sessions in schools and to fund their rape crisis hotlines. As CDC began to shift national attention away from one time public awareness activities to more long term, comprehensive prevention efforts, NDDoH and NDCAWS/CASAND initiated a planning process regarding statewide sexual violence primary prevention. This change in the focus of rape prevention programs was motivated by a lack of satisfaction with the existing prevention programs and national research that was beginning to show that in order to have real changes in behavior, prevention efforts need to be integrated over an extended period of time. Specifically, Nation et al (2003) identified nine characteristics or principles that were consistently associated with effective prevention programs (See Page 95 – Table 3.5). Most sexual violence prevention efforts in North Dakota at the time didn't abide by these principles and tended to focus on shorter, one-time presentations targeting a specific population.

NDCAWS/CASAND has a long history of working in partnership with the NDDoH; a partnership that is unique to our state. NDCAWS/CASAND and NDDoH's relationship extends beyond this project and is unique due to the depth of experience each organization contributes to the partnership. NDDoH's strength lies in public health and injury prevention while NDCAWS/CASAND's experience is in violence against women and advocacy, thereby creating a perfect balance for primary prevention of violence in ND. This partnership would prove essential as primary prevention efforts were enhanced.

### *North Dakota State Capacity Building Team*

The State Capacity Building Team (SCBT) is a work group that was formed in 2006 and is responsible for the overall coordination, administration, and evaluation of the programs. Team members include representatives from the NDDoH, NDCAWS/CASAND, and the Empowerment Evaluation team (from the University of North Dakota, Center for Rural Health (UND CRH) from 2006 to 2009; and World Bridge Research from 2009 to present).

### *North Dakota Intimate Partner Violence and Sexual Violence State Prevention Team (SPT)*

In 2004, a statewide task force designed to investigate sexual violence prevention work geared towards students in middle school through college was convened. To aid in the planning

efforts, the Student Violence Prevention Task Force (SVPTF) distributed a survey and convened focus groups to assess current statewide sexual violence prevention efforts and knowledge and attitudes regarding sexual violence among youth and young adults. The SVPTF's goal was to create a tool kit that would assist local communities with expanding and enhancing their sexual violence prevention work.

The DELTA program, which began in 2003, was beginning to take shape on a statewide and national basis. DELTA's focus was on community mobilization and the primary prevention of intimate partner violence. A small statewide steering committee (SSC) was convened to assist in the selection of communities to be funded under the DELTA program and to act as an advisory committee for these new initiatives.

In early 2005, NDCAWS/CASAND and NDDoH became aware of a national capacity building initiative funded through CDC to focus on sexual violence primary prevention. At this time, the SVPTF was comprised of 12 to 15 people with heavy representation from middles school and campus communities. NDDoH and NDCAWS/CASAND seized on the opportunity to access additional planning and evaluation resources through this new capacity building project, later named the EMPOWER program, to access critically needed training and technical assistance to aid in the efforts to build capacity to address SV via evidence based planning, implementation and evaluation. For the purposes of the capacity building project, the SVPTF and the SSC were merged to focus on intimate partner and sexual violence primary prevention efforts statewide. NDCAWS/CASAND and NDDoH used a community mapping tool to select people from other various disciplines and related prevention fields, such as suicide prevention and representation from local DV/RC agencies.

NDCAWS and NDDoH used Transforming Communities' INSTIGATE! community mapping (www.transformcommunities.org) to select people from other various disciplines and related prevention fields, such as suicide prevention and representation from local DV/RC agencies. The first meeting of the Intimate Partner and Sexual Violence State Prevention Team was held in May 2006. The mission and goals of the State Team have evolved over time with the changes in the DELTA and EMPOWER programs at the national level. Goals were identified early on by NDDoH and NDCAWS/ CASAND prior to the formation of the State Team. After the first meeting, team members requested goals and outcomes for their work. NDDoH and NDCAWS/CASAND created a set of goals and outcomes for the state team to review. The team developed roles and responsibilities and were originally developed to help NDCAWS/CASAND work through the needs and resource assessment. Team membership has evolved over the years although a core group of individuals remain committed to the process.

**Mission Statement:**

***Working together to create a community free of intimate partner and sexual violence in North Dakota.***

**Vision Statement:**

***"All citizens have the right to live in a community free from intimate partner and sexual violence."***

### *Local Entities*

As indicated earlier, NDDoH and NDCAWS/CASAND had a vision for DV/RC agencies to shift from allowable activities under the RPE program to primary prevention planning efforts.

When the RPE Request for Proposals (RFP) was released in February 2005, the NDDoH said that the local DV/RC agencies needed to move away from the original uses of the money such as crisis lines and one-time informational presentations. Local entities were not pleased with the changes made to the RPE program at the February meeting. "We were almost thrown out of the room." A two day training was held on primary prevention, community capacity building, and planning. At the end of the training NDDoH notified local programs that RPE program would be giving $1000 to each program as base funding and the remaining funds were competitive. Prior to this meeting, RPE funds had been distributed based on the number of sexual assault victims served. Initially, 14 DV/RC agencies participated in the prevention-focused RPE program. Unfortunately, due to funding constraints and competing demands, that number has decreased; currently, 9 agencies are funded under RPE and are in the process of creating and implementing a sexual violence primary prevention plan for their community.

DELTA grants were awarded in September 2002 to nine states; ND was funded (with 5 others) in January 2003. NDCAWS/CASAND had to create an RFP to select programs around North Dakota. NDCAWS/CASAND distributed the RFP in the summer of 2003. Ten programs applied for the two pots of money, rural--$14,800 (3) and urban--$22,320 (3) to focus on primary prevention of intimate partner domestic violence. DV/RC agencies were required to work with local coordinated community taskforces to plan and implement prevention programming. Initially, programs were encouraged to select a target population and sector of the community to work with, in anticipation of "ready-made" prevention programming they could adapt and implement. Early on it became clear that this programming didn't exist. Communities began to explore opportunities to learn more about their population by conducting surveys and focus groups and began to test strategies and programs that focused on the information they gathered. Three years into the process a new RFP was awarded that allowed programs to continue strategies and programs they had adapted while also beginning to develop a prevention plan for their community.

In addition to the creation of a state plan for intimate partner and sexual violence prevention, local communities across ND have created plans for their areas. Nine communities across the state followed the Getting to Outcomes (GTO) process to examine their needs and resources and create goals and activities based on their areas of need. Two goals were selected for each, a population goal and a capacity goal. The communities then selected strategies and activities to help them achieve their goals. Plans were developed in nine communities and are currently being implemented in seven of those communities (as indicated with * in Figure 1.1).

***Beulah: RPE**
**Mercer County Intimate Partner Violence and Sexual Violence Prevention Team**
*Women's Action and Resource Center*

***Bismarck: DELTA & RPE**
**PULSE- People United for Living in Safe Environments**
*Abused Adult Resource Center*

**Devils Lake: RPE**
**Towner County Community Action Team**

*Safe Alternatives for Abused Families*

**Dickinson: DELTA**
**Stark County Coalition Against Domestic Violence**
*Domestic Violence and Rape Crisis Center*

***Fargo: DELTA & RPE**
**Cass County Intimate Partner Violence and Sexual Violence Prevention Team**
*Rape and Abuse Crisis Center*

***Grand Forks: DELTA & RPE**
**DELTA-RPE Advisory Committee**
*Community Violence Intervention Center*

***Jamestown: RPE**
**Empower Team**
*Safe Shelter*

***Minot: RPE**
**Minot Sexual Violence Prevention Team**
*Domestic Violence Crisis Center*

***Stanley: DELTA & RPE**
**Mountrail County Domestic Violence & Sexual Assault Task Force**
*Domestic Violence Program of Northwestern North Dakota*

***Valley City: RPE**
**Safe Community Coalition**
*Abused Persons Outreach Center*

*Figure 1.1.* Local Prevention Teams – Domestic Violence/Rape Crisis Agencies

## DEFINITIONS

In order to understand data about IPV and SV, knowing what terms mean is critical. Comparing information from different sources can be challenging when different definitions are used for the same term. For instance, rates of sexual violence vary in part because different entities define sexual violence differently. Therefore, terms used throughout this study are first defined to help make sense of the information presented. Although these varying definitions are important to understand the similarities and differences in the data that is presented, it can also be confusing. In order to provide some clarity and consistency, for the purposes of this report, the CDC definition will be used for this project.

### *Intimate Partner Violence (IPV) and Sexual Violence (SV)*

In ND, domestic violence is more narrowly defined as a physical act within a family or household member. The US Department of Justice (DOJ), like ND, includes different types of physical abuse but further defines the different types of emotional abuse. The CDC defines IPV

broadly, including a broad range of acts; definition of partners, both males and females; and gay and straight couples.

| | |
|---|---|
| **STATE - ND** | ***North Dakota Century Code Chapter 14-07.1:***<br><br>**Domestic violence** includes physical harm, bodily injury, sexual activity compelled by physical force, assault, or the infliction of fear of imminent physical harm, bodily injury, sexual activity compelled by physical force, or assault, not committed in self-defense, on the complaining family or household members.<br><br>*www.legis.nd.gov/cencode/* |
| **NATIONAL - DOJ** | ***United States Department of Justice (DOJ):***<br><br>**Domestic violence** can be defined as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone.<br><br>*US Department of Justice, 1996* |
| **NATIONAL – CDC** | ***Centers for Disease Control:***<br><br>For the purpose of this report, **intimate partner violence** (IPV) is defined as physical violence, sexual violence, threats of physical or sexual violence, psychological/emotional abuse and stalking. The types of intimate partnerships included are current spouses, former spouses, current non-marital partners, and former non-marital partners. There is no minimum time requirement for a relationship to be considered an intimate partner relationship as first dates and long-term boyfriend and girlfriend relationships are included under the term non-marital partners. Additionally, being an intimate partner does not require current cohabitation or sexual activities between two individuals. Intimate partners may also be of the same-sex or opposite sex.<br><br>*CDC/National Center for Injury Prevention and Control (NCIPC)- DELTA definition of IPV* |

Sexual violence in ND is very concretely defined as contact between body parts. The DOJ definition is much broader; for instance, visual actions can be considered as SV with this definition. Again, the CDC defines SV broadly, including a broad range of acts.

| | |
|---|---|
| **STATE - ND** | ***North Dakota Century Code Chapter 12.1-20:***<br><br>**Sex Offenses- Sexual Act** means sexual contact between human beings consisting of contact between the penis and the vulva, penis and the anus, the mouth and the penis, the mouth and the vulva, or any other portion of the human body and the penis, anus, or vulva; or the use of an object which comes in contact with the penis, vulva, or anus.<br><br>*www.legis.nd.gov/cencode/* |

**NATIONAL - DOJ**

***United States Department of Justice (DOJ):***

**Sexual assault** can be defined as any type of sexual contact or behavior that occurs without the explicit consent of the recipient of the unwanted sexual activity. Falling under the definition of sexual assault is sexual activity such as forced sexual intercourse, sodomy, child molestation, incest, fondling, and attempted rape. Some more specific examples of sexual assault include:

- Unwanted vaginal, anal, or oral penetration with any object
- Forcing an individual to perform or receive oral sex
- Forcing an individual to masturbate, or to masturbate someone else
- Forcing an individual to look at sexually explicit material or forcing an individual to pose for sexually explicit pictures
- Touching, fondling, kissing, and any other unwanted sexual contact with an individual's body
- Exposure and/or flashing of sexual body parts

*US Department of Justice, 1996*

**NATIONAL - CDC**

***Centers for Disease Control***:

**Sexual violence** (SV) is a sex act completed or attempted against a victim's will or when a victim is unable to consent due to age, illness, disability, or the influence of alcohol or other drugs. It may involve actual or threatened physical force, use of guns or other weapons, coercion, intimidation or pressure. Sexual violence also includes intentional touching of the genitals, anus, groin, or breast against a victim's will or when a victim is unable to consent, as well as voyeurism, exposure to exhibitionism, or undesired exposure to pornography

*Basile and Saltzman, 2002*

### *Primary Prevention*

Primary prevention or preventing violence from initially occurring is a relatively new concept to the domestic violence and sexual assault field.

Primary prevention focuses on addressing the conditions that support IPV, promoting conditions that inhibit IPV, and promoting behaviors you want others to adopt.

**Primary prevention** activities are those directed at the general population, or a subset of the general population, designed to actively promote healthy, non-violent relationships.
In other words, primary prevention seeks to reduce the overall likelihood that anyone will become a victim or a perpetrator by creating conditions that make violence less likely to ever occur.

*CDC DELTA Collaborative*

### *Risk and Protective Factors*

The concept of risk and protective factors comes from a concern about identifying cause of behaviors and realizing that many factors interact to create a situation. Therefore, it may not be possible to "prove" that one action caused an outcome, but research can identify a number of factors or risk factors that are correlated with a particular outcome. Identifying a risk factor for perpetrating or being a victim might provide one a point where an intervention might interrupt the process and prevent an undesired outcome. The concept of risk factors originated in the health field and has expanded to other arenas. The CDC's national program to measure health risk factors is the Behavioral Risk Factor Surveillance System, an annual survey (http://www.cdc.gov/brfss/). This information provides helpful data; it is based on self-report and only measures individual risk factors from that individual's perspective.

## CONCEPTUAL FRAMEWORK

The conceptual framework for the development of this plan it an important component in understanding the process that was followed. Empowerment Evaluation project is based on the public health approach to prevention, using an ecological approach. Getting to Outcomes provides the framework for developing, implementing, and evaluating prevention models. In addition, a theoretic base for what causes violence is important to examine prior to selecting strategies to prevent violence.

### *Public Health Approach to Prevention*

The DELTA and EMPOWER projects use a public health approach to prevent IPV and SV, focusing on "the health of a population rather than one individual" (Brome, Saul, Lang, Lee-Ptehel, Rainford, & Wheaton, 2004, p. 2). Tenets of the public health approach include benefiting the largest number of people possible, using data, and implementing evidence-based approaches. The public health approach contains four steps (see Figure 1.2).

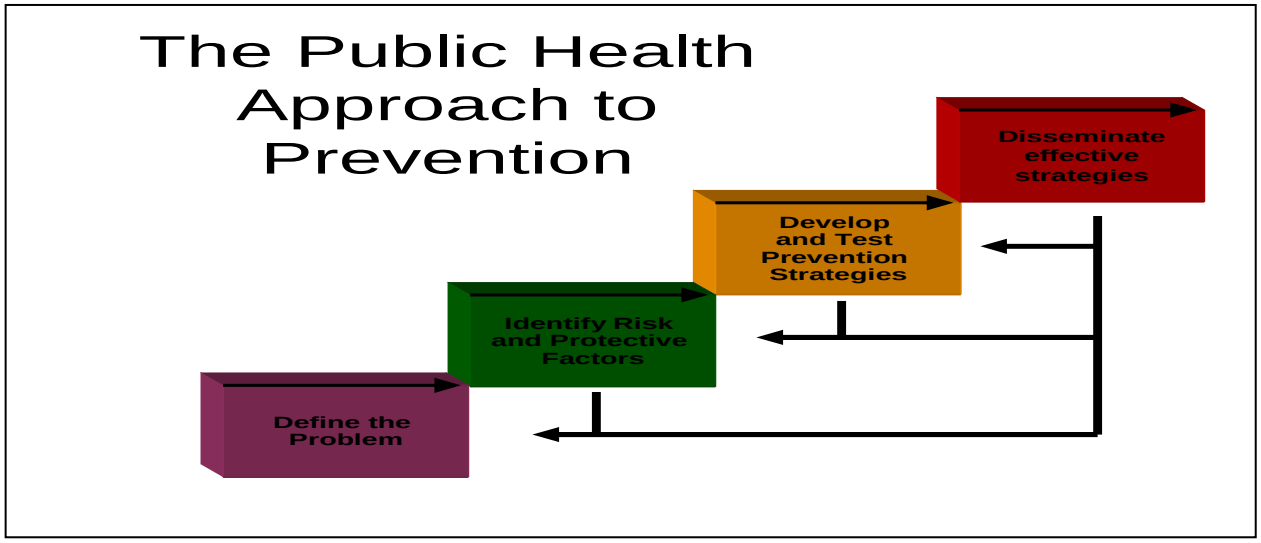
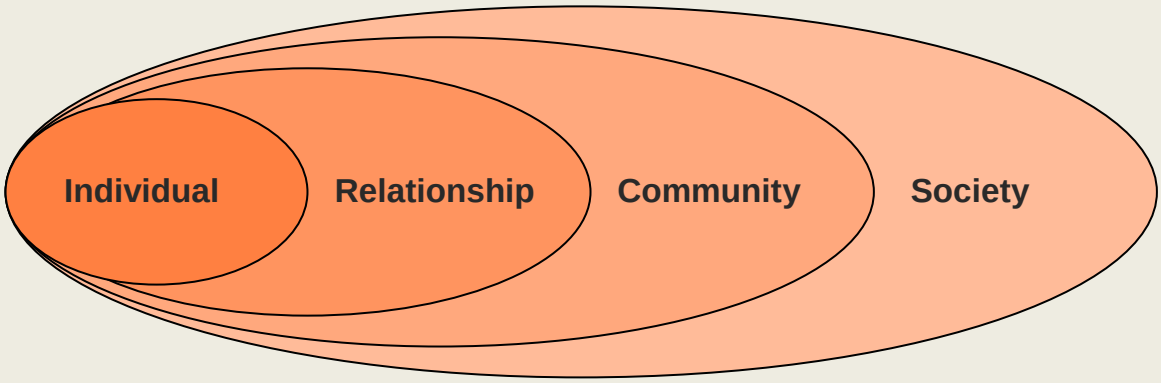



*Figure 1.2.* The Public Health Approach to Prevention

The ultimate goal is to stop violence before it begins. Prevention requires understanding the factors that influence violence. CDC uses a four-level social-ecological model to better understand violence and the effect of potential prevention strategies (Dahlberg & Krug 2002). This model considers the complex interplay between individual, relationship, community, and societal factors. It allows us to address the factors that put people at risk for experiencing or perpetrating violence.




*http://www.cdc.gov/ncipc/dvp/Social-Ecological-Model_DVP.htm*

*Figure 1.3.* Social Ecological Model

### *Empowerment Evaluation and Getting to Outcomes*

Many people have been trying to develop methods to improve outcomes for prevention programs, given how important preventing harm is and how expensive programming is. One method that many programs have used is community based participatory research. This philosophy states that receiving feedback throughout the life of the project improves the development of the project. Involving people who are part of the evaluation in the development and implementation of the evaluation improves the evaluation and the use of the results of evaluation. Empowerment Evaluation is one example of this type of evaluation process. Research has supported the effectiveness of community based participatory research and of empowerment evaluation. Empowerment Evaluation does have some drawbacks. It is time intensive, requires buy-in from a large group of people, and requires constant attention to fidelity, the accurate application of the model.

**Empowerment Evaluation** is an evaluation approach that aims to increase the likelihood that programs will achieve results by increasing the capacity of program stakeholders to plan, implement, and evaluate their own programs. Ten principles guide every part of empowerment evaluation, from conceptualization to implementation. The ten principles of empowerment evaluation are **improvement, community ownership, inclusion, democratic participation, social justice, community knowledge, evidence-based strategies, capacity building, organizational learning, and accountability.**

*Fetterman and Wandersman, 2005*

Getting to Outcomes (GTO) is the application of Empowerment Evaluation (see Figure 1.4). It has been used in the substance use field to prevent risky behavior surrounding illegal substance use and substance abuse. The Centers for Disease Control selected this model for intimate partner and sexual violence programming and is in the process of adapting it to fit the DELTA and EMPOWER models.

**GTO** is a framework of 10 accountability questions for planning, implementing, evaluating, and achieving success. (SAMHSA, 2000)

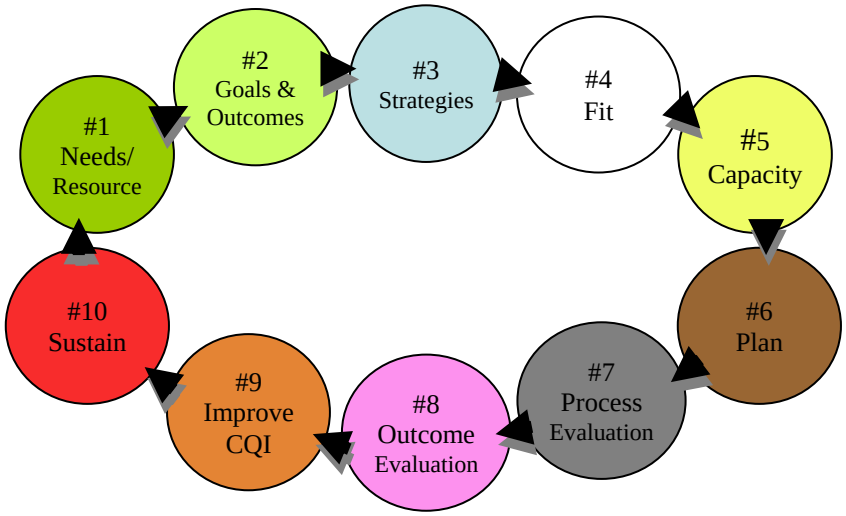



*Figure 1.4.* Getting to Outcomes Framework

### *Theories Regarding Cause of Intimate Partner and Sexual Violence*

For years researchers, advocates, and other professionals have debated the cause of intimate partner and sexual violence. Many theories have been incorporated to explain intimate partner and sexual violence and to create effective intervention and prevention strategies.

#### *Bio-ecological Theory*

Broffenbrenner and Ceci (1994) demonstrated that biology and environment interact to drive human behavior. This systemic view of "cause" undergirds primary prevention efforts to reduce violence. Factors at the individual, family, community, and societal interact to support or change behaviors and risk factors that contribute to those behaviors. Based on this theory, one must address risk factors at all levels in order to prevent intimate partner and sexual violence.

#### *Individual and Family Theories Regarding Violence*

Other theories used to explain the causes of intimate partner and sexual violence include the individual orientation, which examines the characteristics of the offender and the victim that contribute to violence (Buzawa and Buzawa, 1990). Individual oriented theories focus on individual stressors such as poverty, low self esteem, poor self control, and mental health issues such as depression. Offenders are seen as men who externalize blame, rationalizing their actions

and blaming victims (Dobash and Dobash, 1979). In contrast, family oriented theories argue that the family unit is a unique social group with a high potential for frustration and violence (Farrington, Straus, & Hotaling, 1980). Traditional family systems theory supported the idea that the "cause" of violence lay in the family system, not individuals (Murray, 2006). Buzawa and Buzawa (1990) found isolation, children witnessing violence in the home, high levels of marital conflict and male use of control in the relationship were all predictors of future violence in relationships. An updated study in 2001 (Samuels) found similar results.

### *Feminist Theory*

The feminist perspective explains intimate partner and sexual violence from a structural perspective that focuses on male dominance and power and control over women. Women are viewed as unable to manage their own affairs without the strong leadership from an authoritarian family patriarch. Law, religion, and behavioral sciences have endorsed a husband's authority and justify the use of violence to punish a disobedient wife (Schecter, 1982). Male dominance and inequality are often noted as the key factors contributing and causing intimate partner and sexual violence (IPV and SV). In an effort to incorporate recent research and thinking into the feminist model regarding intimate partner violence, McPhail, Busch, Kulkarni, and Rice (2007) developed the Integrative Feminist Model, retaining "a focus on the political and structural problems" (p. 826) and using multiple theories to explain individual behavior, including biology and environment, incorporating the notion of female violence, while recognizing the ongoing conflict between a value for choice and a determination that violence is not an acceptable choice.

### *The Underlying Theory of the Rape Prevention and Education Model of Social Change (CDCP)*

Consistent with the social ecological model, the underlying causes of sexual assault are complex and multifaceted, and as a result, primary prevention efforts must target multiple levels of analysis. In order to prevent sexual violence from initially occurring (primary prevention) prevention efforts will require changing the norms, climate, and culture of communities. At the same time, individuals within our communities must also change their behaviors and choose not to be sexually abusive to their peers, to their friends, to their families, or to strangers. This presents a challenge for sexual violence prevention efforts: a theoretical model is needed that articulates how to promote both community change and individual behavior change. The CDC RPE Theory and Activities Models were based on Diffusion of Innovation Theory (DOI) (Rogers, 1995) which is a theory of how to bring about community-level changes, and three theories of individual behavior change: Theory of Reasoned Action (TRA), Theory of Planned Behavior (TPB), and the Health Belief Model (HBM) (Biglan, 1995; Glanz, Rimer, & Lewis, 2002).

# CHAPTER TWO: NEEDS AND RESOURCES ASSESSMENT

Intimate partner and sexual violence are preventable public health issues. To create a framework for prevention in North Dakota (ND), the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA), Enhancing and Making Programs and Outcomes Work to End Rape (EMPOWER) the DELTA and EMPOWER projects have joined with North Dakota's Rape Prevention Education (RPE) program to work with the State Prevention Team (SPT) and local Domestic Violence/Rape Crisis (DV/RC) agencies to prevent violence. The North Dakota Intimate Partner and Sexual Violence State Prevention Team (SPT) completed this needs and resource assessment, using the Empowerment Evaluation model. Using the innovative Empowerment Evaluation (EE) and Getting to Outcomes (GTO) framework, the results of the Needs and Resource Assessment will guide the development of the State IPV and SV Prevention Plan. Once an understanding of the magnitude of IPV and SV is established and awareness of the resources and gaps for prevention of violence in ND are known, the SPT will have the information to make decisions regarding primary prevention goals and activities to inform the primary prevention plan.

Local Needs and Resources Assessments were also conducted. Although some local data is included in this State Report, full reports are available for the following counties/areas: Barnes, Burleigh/Morton, Cass/Traill, Grand Forks, Mercer, Mountrail, Stark, Stutsman, Towner, and Ward.

The Needs and Resources Assessment is comprised of the following sections:

- Definitions
- North Dakota State Profile
- Resources in North Dakota for Primary Prevention
- Magnitude of Intimate Partner Violence
- Magnitude of Sexual Violence
- Risk and Protective Factors
- Conclusions

## Definitions

A "picture" of ND was created based on U. S. Census data, to understand the context in which violence occurs (see Chapter 2). Definitions from the U.S. Census Bureau help clarify the information presented.

**Urban:** All territory, population and housing units in urbanized areas and in places of more than 2,500 persons outside of urbanized areas. "Urban" classification cuts across other hierarchies and can be in metropolitan or non-metropolitan areas.

**Urban Area:** Collective term referring to all areas that are urban. For Census 2000, there are two types of urban areas: urban clusters and urbanized areas.

**Urban Cluster** (UC): A densely settled territory that has at least 2,500 people but fewer than 50,000. New for Census 2000.

**Urbanized area** (UA): An area consisting of a central place(s) and adjacent territory with a general population density of at least 1,000 people per square mile of land area that together have a minimum residential population of at least 50,000 people. The Census Bureau uses published criteria to determine the qualification and boundaries of UAs.

**Rural:** Territory, population and housing units not classified as urban. "Rural" classification cuts across other hierarchies and can be in metropolitan or non-metropolitan areas.

**Population density:** Total population within a geographic entity (for example, United States, state, county, place) divided by the land area of that entity measured in square kilometers or square miles. Density is expressed as both "people per square kilometer" and "people per square mile" of land area.

*http://www.census.gov/*

### *Measurement*

How data is measured influences its interpretation. Magnitude can be presented based on a ***point in time*** measure, how many people experience an event at one measurement time. This is the method used to measure the rate of homelessness in America. A 24 hour period is designated, and across the country entities count and report the numbers of people who are homeless in their community during that time period to arrive at an aggregate number. A ***cross-sectional*** measure is similar, but it might look slightly different. For instance, the 2000 census is a cross-sectional measure, with information being collected during one year. It becomes ***longitudinal*** when the measure is repeated, as the Census is when considered from its inception in 1900 to 2000. ***Lifetime prevalence*** asks one person to think back and report how many times an event has happened to them in their lifetime.

Statistical and research terms frequently used in research articles about prevention of violence include:

**Mean, Median, and Mode**: Different ways to measure "average" scores.

**Correlated**: Two variables change together. For instance, as a child's age increases, her or his height increases. The relationship may also be negative: As the price of gas increases, the number of miles driven during a vacation decreases.

**Statistically Significant**: This is a mathematical calculation of how strong the correlation, or relationship between two variables, is.

**Evidence-Based Strategies: S**trategies that are “determined by a process in which experts, using commonly agreed upon criteria for rating interventions, come to a consensus that evaluation research findings are credible and can be substantiated” (*Chinman, Imm, & Wandersman, 2004).*

## North Dakota Profile

In order to better understand the data regarding intimate partner and sexual violence in ND, the ND state profile, based on 2000 Census data, was created. It assists in decision making regarding targets for IPV and SV prevention. Almost half of ND is considered rural (44%). More North Dakotans are female; the number of women over the age of 60 is much greater than the number of males. The majority of North Dakotans are considered Caucasian; the largest minority group is American Indian (5.5%). Sixty-five percent of households in ND are considered to be family households, with 54% being married-couple families. North Dakota has a lower unemployment rate (4.6%) and per capita income ($17,769) than the national average, but fewer people are living in poverty (8.3% of families below the poverty level). Eighty-four percent of North Dakotans have at least a high school diploma and 22% have a bachelor's degree or higher. This information sets the context for understanding violence in ND.

### *Density*

Most of ND is sparsely populated. Forty-four percent of ND's population is designated rural (see Table 2.1). The overall density of ND is 9.5 persons per square mile (see Figure 2.1). More counties have less than 9 persons per square mile. Only one county, Cass County, has 70 persons per square mile.

Table 2.1. *Population of Urban and Rural Designation*

| Level of Rurality | N | % |
|---|---|---|
| Urban | 358,958 | 56 |
| Inside urbanized areas | 230,797 | |
| Inside urban clusters | 128,161 | |
| Rural | 283,242 | 44 |
| Total | 642,200 | 100 |

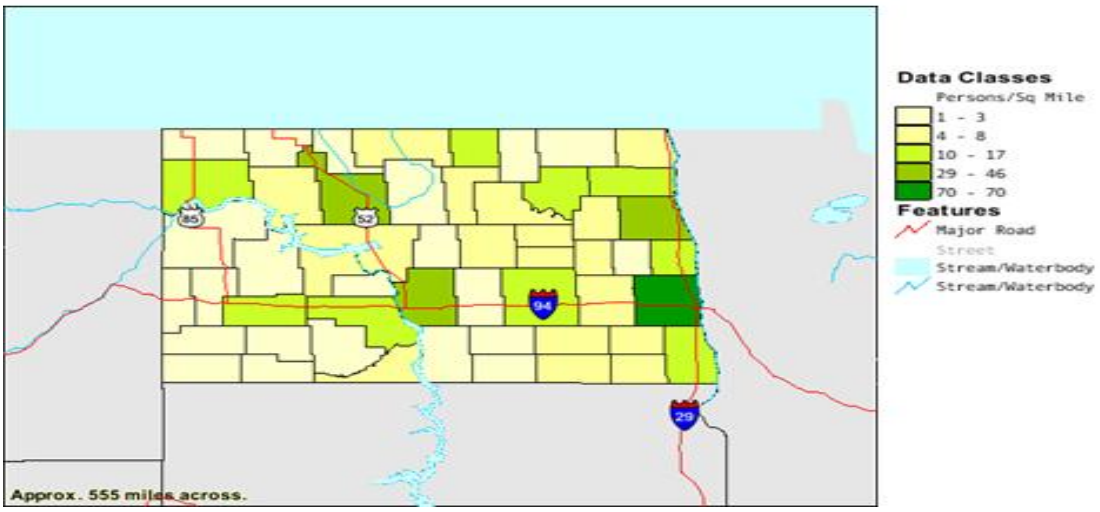



*Figure 2.1*. Population Density

### *Gender*

Overall, slightly more than half of North Dakota's population is female (51%) (see Figure 2.2 and Table 2.2). There are more males than females from birth to age 60; then, the male to female ratio drops dramatically as age increases.

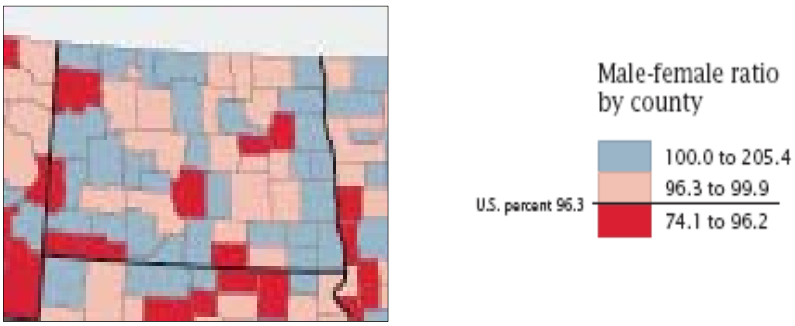



*Figure 2.2.* Male – Female Ratio by County

Table 2.2. *Gender Distribution by Age*

| Age | N | | | % | | |
|---|---|---|---|---|---|---|
| | Both | Male | Female | Both | Male | Female |
| 5-9 years | 43,223 | 22,264 | 20,959 | 6.7 | 6.9 | 6.5 |
| 10-14 years | 47,602 | 24,459 | 23,143 | 7.4 | 7.6 | 7.2 |
| 15-19 years | 53,048 | 27,681 | 25,367 | 8.3 | 8.6 | 7.9 |
| 20-24 years | 50,648 | 26,918 | 23,730 | 7.9 | 8.4 | 7.4 |
| 25-29 years | 38,809 | 20,172 | 18,637 | 6.0 | 6.3 | 5.8 |
| 30-34 years | 37,807 | 19,475 | 18,332 | 5.9 | 6.1 | 5.7 |
| 35-39 years | 47,747 | 23,776 | 23,971 | 7.4 | 7.4 | 7.5 |
| 40-44 years | 50,894 | 25,748 | 25,146 | 7.9 | 8.0 | 7.8 |
| 45-49 years | 47,768 | 24,470 | 23,298 | 7.4 | 7.6 | 7.2 |
| 50-54 years | 37,696 | 19,426 | 18,270 | 5.9 | 6.1 | 5.7 |
| 55-59 years | 28,620 | 14,316 | 14,304 | 4.5 | 4.5 | 4.4 |
| 60-64 years | 24,647 | 12,024 | 12,623 | 3.8 | 3.7 | 3.9 |
| 65-69 years | 23,037 | 10,736 | 12,301 | 3.6 | 3.3 | 3.8 |
| 70-74 years | 22,964 | 10,533 | 12,431 | 3.6 | 3.3 | 3.9 |
| 75-79 years | 19,012 | 8,181 | 10,831 | 3.0 | 2.6 | 3.4 |
| 80-84 years | 14,922 | 5,786 | 9,136 | 2.3 | 1.8 | 2.8 |
| 85-89 years | 9,479 | 3,284 | 6,195 | 1.5 | 1.0 | 1.9 |
| 90 years and older | 5,183 | 1,374 | 3,809 | 0.8 | 0.4 | 1.2 |
| Total | 642,200 | 320,695 | 321,505 | 100 | 49.9 | 51.1 |

North Dakota's median age is 36.2 years old, compared with the national median age of 35.3. The youngest median age (23.9 – 32.4) is found in the counties of Rollete, Ward, Benson, Cass and Sioux (see Figure 2.3).

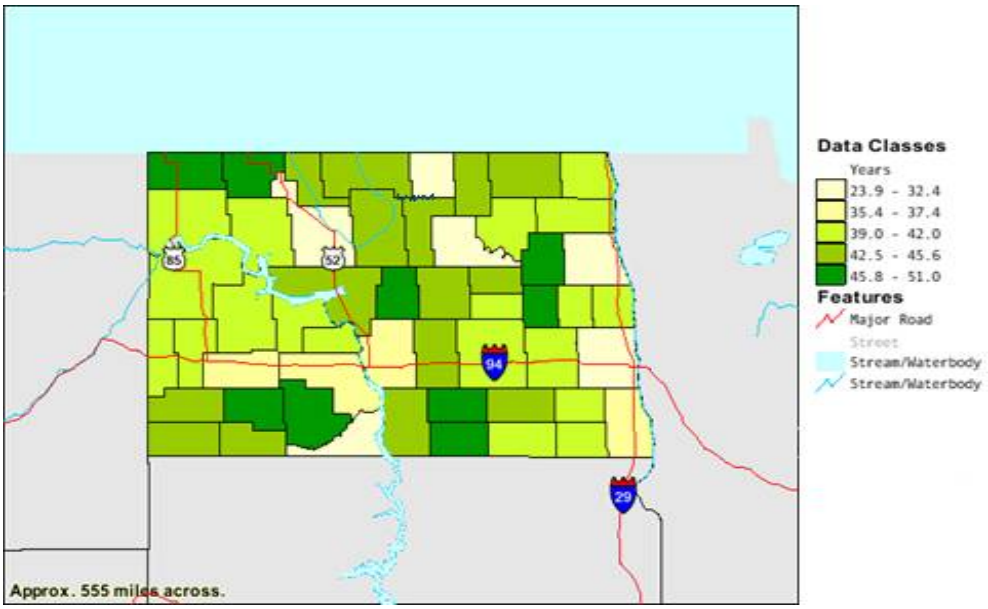



*Figure 2.3.* Median Age

***Race***

The primary racial groups in ND are American Indian (5.5%) and white (93.4%). The majority of the population of North Dakota is white. Other racial groups comprise 2.1% of the population (see Table 2.3). The median age for American Indians (22 years old) is lower than ND as a whole (see Table 2.4).

Table 2.3. *Racial Groups*

| Race | N | % |
|---|---|---|
| White | 599,918.00 | 93.4 |
| Black or African American | 5,372.00 | 0.8 |
| American Indian and Alaska Native | 35,228.00 | 5.5 |
| Asian | 4,967.00 | 0.8 |
| Native Hawaiian and Other Pacific Islander | 475.00 | 0.1 |
| Other race alone or in combination | 4,042.00 | 0.6 |
| Total | 642,200.00 | 100.0 |

Table 2.4. *American Indian, Median Age*

| Age | N | % |
|---|---|---|
| Under 5 years | 3,353 | 10.7 |
| 5 to 9 years | 3,575 | 11.4 |
| 10 to 14 years | 3,970 | 12.7 |
| 15 to 19 years | 3,305 | 10.6 |
| 20 to 24 years | 2,646 | 8.5 |
| 25 to 34 years | 4,328 | 13.8 |
| 35 to 44 years | 4,425 | 14.1 |
| 45 to 54 years | 2,783 | 8.9 |

| | | |
|---|---|---|
| 55 to 59 years | 875 | 2.8 |
| 60 to 64 years | 648 | 2.1 |
| 65 to 74 years | 921 | 2.9 |
| 75 to 84 years | 410 | 1.3 |
| 85 years and over | 69 | 0.2 |

### *Household*

Sixty-five percent of the households in ND are considered to be family households. Fifty-four percent of those households are married couple families, while 7.6% are female households with no husband present (see Table 2.5).

Table 2.5. *Type of Household*

| Household Type | N | % |
|---|---|---|
| Family households (families) | 166,963 | 64.9 |
| With own children under 18 years | 81,226 | 31.6 |
| Married-couple family | 139,203 | 54.1 |
| With own children under 18 years | 63,541 | 24.7 |
| Female householder, no husband present | 19,561 | 7.6 |
| With own children under 18 years | 13,097 | 5.1 |
| Nonfamily households | 90,271 | 35.1 |
| Householder living alone | 75,324 | 29.3 |
| Householder 65 years and over | 29,646 | 11.5 |
| Total Households | 257,234 | 100 |

The number of all households with individuals under 18 and over 65 is about the same, 33% (see Table 2.6).

Table 2.6. *Household by Age*

| Household by Age | N | % |
|---|---|---|
| Households with individuals under 18 years | 84,604 | 32.9 |
| Households with individuals 65 years and over | 86,602 | 33.7 |

Forty-five percent of American Indian households have individuals under 18 who are their own children (see Table 2.7). Thirty-two percent are female-headed households with no husband present.

Table 2.7. *American Indian Households*

| Household Type | N | % |
|---|---|---|
| Family households (families) | 6,848 | 76.7 |
| With own children under 18 years | 4,648 | 52.1 |
| Married-couple family | 3,183 | 35.7 |
| With own children under 18 years | 2,019 | 22.6 |
| Female householder, no husband present | 2,835 | 31.8 |
| With own children under 18 years | 2,027 | 22.7 |

| | | |
|---|---|---|
| Nonfamily households | 2,077 | 23.3 |
| Householder living alone | 1,568 | 17.6 |
| Householder 65 years and over | 424 | 4.8 |

### *Income and Employment*

Compared to other states, ND has a lower unemployment rate (4.6%) than the national average. The unemployment rate for people who are American Indian is 11%. ND per capita income is lower than the national average ($17,769), but fewer people are in poverty (8.3% of families below the poverty level) (see Table 2.8). Cass and Burleigh Counties have the highest per capita income ($20,436-$20,889), while Rolette, Benson, and Sioux have the lowest per capita income ($7,731-$11,509) (see Figure 2.4).

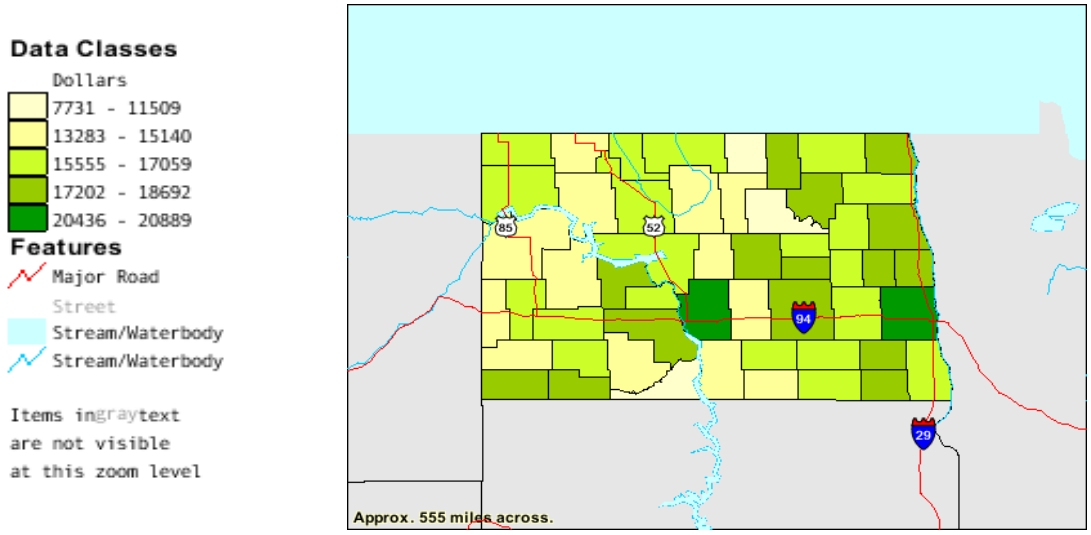



*Figure 2.4.* Per Capita Income

The counties with the highest number of persons living below the poverty line include Rolette, Benson, and Sioux County (29.1%-39.2% below poverty level) (see Figure 2.5).

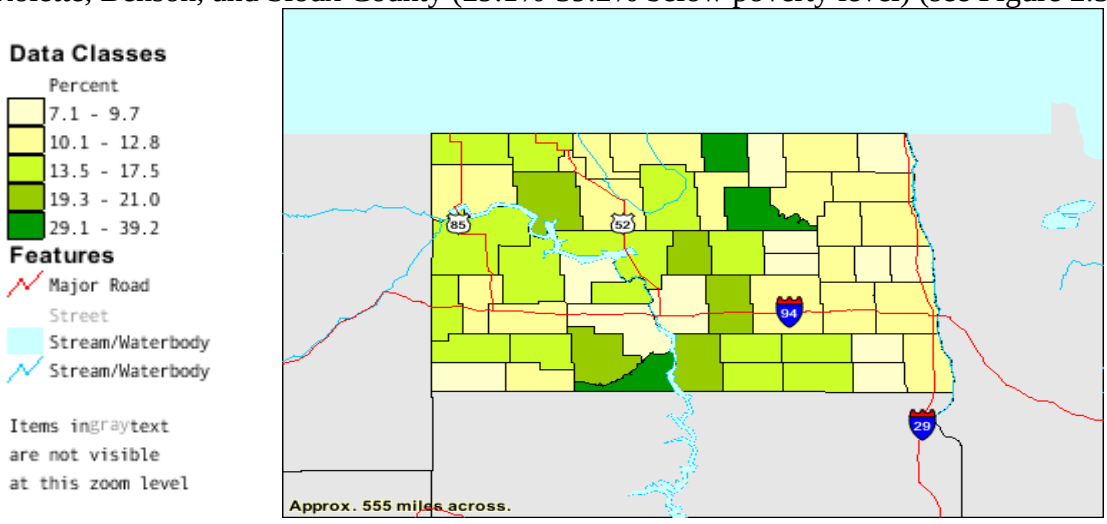



*Figure 2.5.* Percent Living Below the Poverty Line

Thirty-six percent of people who are American Indian live below the poverty level; 42% of people who are American Indian with children under 18 live below the poverty level (see Table 2.8). Married couple families have a much higher median income than female householders or nonfamily.

Table 2.8. *Marital Status and Income of Persons Who Are American Indian*

| Income | Households | Total families | Married couple families | Female householder no husband present | Nonfamily households |
|---|---|---|---|---|---|
| Less than $10,000 | 28,417 | 9,133 | 4,124 | 4,086 | 20,120 |
| $10,000 to $14,999 | 20,575 | 7,998 | 4,404 | 2,944 | 13,134 |
| $15,000 to $19,999 | 20,153 | 9,540 | 5,979 | 2,712 | 11,165 |
| $20,000 to $24,999 | 21,171 | 10,873 | 7,647 | 2,363 | 10,413 |
| $25,000 to $29,999 | 20,441 | 11,961 | 9,247 | 1,816 | 8,649 |
| $30,000 to $34,999 | 19,177 | 12,383 | 10,173 | 1,397 | 6,705 |
| $35,000 to $39,999 | 17,363 | 12,290 | 10,499 | 1,096 | 4,750 |
| $40,000 to $44,999 | 16,320 | 12,287 | 10,911 | 852 | 3,702 |
| $45,000 to $49,999 | 14,127 | 11,343 | 10,348 | 584 | 2,605 |
| $50,000 to $59,999 | 23,839 | 19,957 | 18,604 | 815 | 3,432 |
| $60,000 to $74,999 | 23,710 | 20,829 | 19,980 | 422 | 2,494 |
| $75,000 to $99,999 | 17,389 | 15,426 | 14,806 | 261 | 1,664 |
| $100,000 to $124,999 | 6,724 | 5,993 | 5,800 | 60 | 636 |
| $125,000 to $149,999 | 2,974 | 2,644 | 2,548 | 52 | 285 |
| $150,000 to $199,999 | 2,229 | 2,040 | 1,945 | 61 | 185 |
| $200,000 or more | 2,625 | 2,266 | 2,188 | 40 | 332 |
| Total | 257,234 | 166,963 | 139,203 | 19,561 | 90,271 |
| Median income (dollars) | 34,604 | 43,654 | 48,006 | 20,075 | 20,296 |
| Mean income (dollars) | 43,560 | 52,189 | 57,047 | 24,887 | 26,327 |

### *Education*

Eighty-four percent of North Dakotans have a high school degree and 22% have a bachelor's degree or higher. In the age groups of 25 to 44, more females than males have a bachelor's degree.

### *Homeless*

According to the ND Coalition for Homeless People's (NDCHP) point in time survey on January 5, 2006, 739 people were homeless in ND. Of those 739 people, 39% slept in emergency shelters, 27% slept in transitional housing, and 13% slept at a family or friends home. The average homeless person in ND has been homeless for 182 days.

## Potential Resources for Prevention

### *North Dakota's Potential Prevention Resources*

ND has a wide array of resources available on both a state and local level. Many of the existing resources that may strengthen the prevention efforts in ND are represented in the North Dakota Resource Ecomap (see Figure 2.6). Six resource categories were developed by the Resource Subgroup of the State Prevention Team: community organizations, youth organizations, law and legal enforcement, school based resources, data sources, and medical resources. Each main category has four subcategories. For instance, the law and legal enforcement category has four subcategories that represent resources at the state, tribal, county, and local level.

Although this Ecomap does not include every resource, it is a detailed picture of many of the resources available in ND for IPV and SV prevention of which we are aware at this time. It includes potential partners for primary prevention of IPV and SV, as well as those already working with primary prevention in other areas such as substance abuse and tobacco prevention. Some partners may be able to assist financially, while others will be able to help implement strategies for IPV and SV primary prevention. The agencies listed on the Ecomap are a critical component in spreading the prevention message to the general public, as well as to targeted populations within the state.

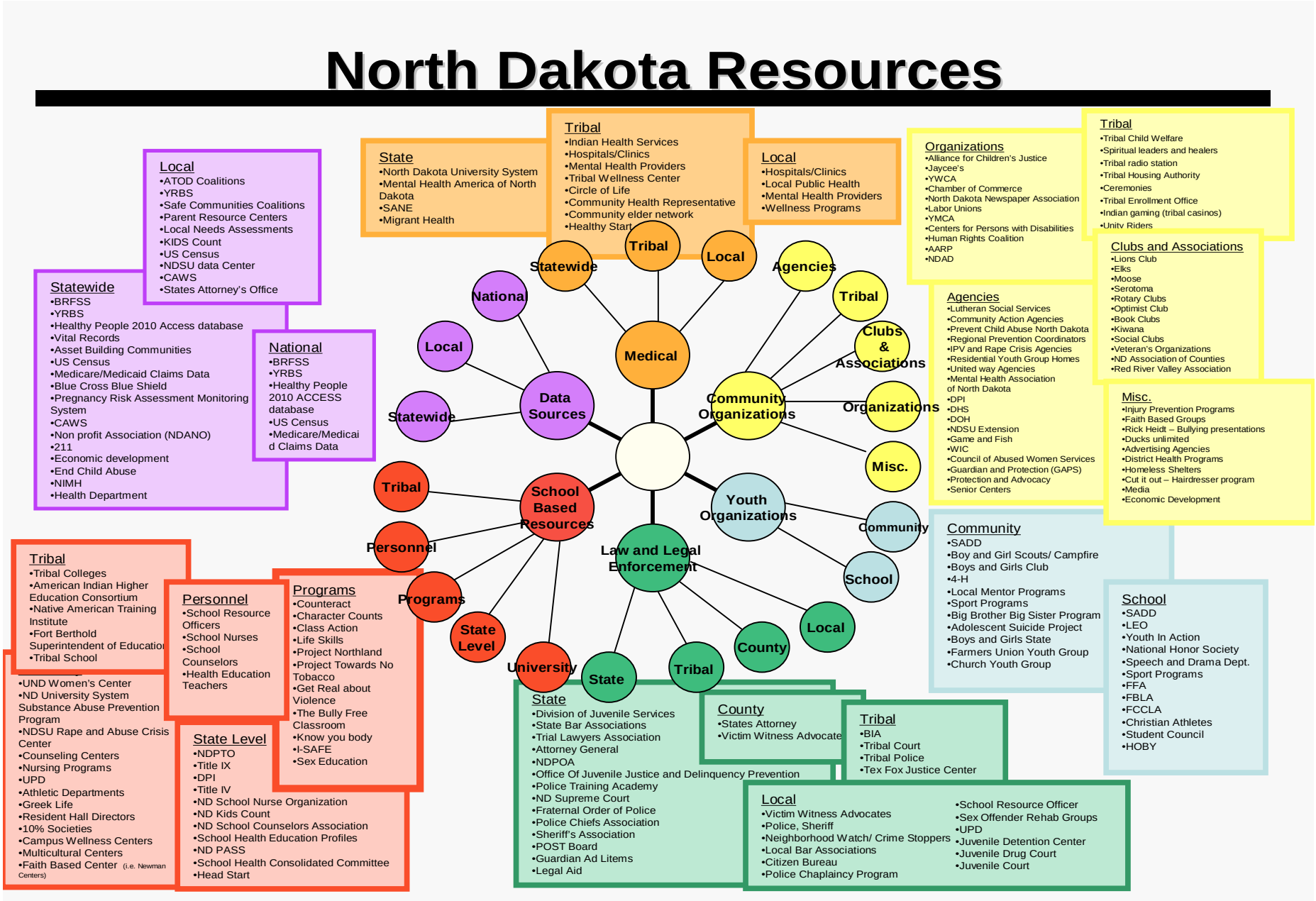



*Figure 2.6.* North Dakota Ecomap of Prevention Resources

### *Youth Organizations*

Community and school based youth organizations are important resources available in ND (see Figure 2.7). Many community organizations are already using techniques to address prevention efforts in other areas such as substance abuse. Frequently, the mentoring model for working with children, which is considered evidence-based practice, individually and in groups, is being used by organized youth groups. Some of these groups have violence prevention programs that are already part of a curriculum at the community level. School based organizations are critical partners because they provide access to children and adolescents and may already have implemented general violence prevention programs. Elementary schools are more likely to have bully prevention programs such as Character Counts and Counteract. Schools with Family, Career and Community Leaders of America (FCCLA) may have chosen to use STOP the Violence, Students Taking on Prevention, as a peer-to-peer outreach initiative that empowers young people to recognize, report and reduce the potential for youth violence. Other examples of school based violence prevention programs include the Students Against Destructive Decisions (SADD), who have developed an action plan - Stop the Violence; the National Honor Society; and the National Junior Honor Society chapters around the state who participate in character building activities on an annual basis. Through the use of existing groups and organizations serving youth, we hope to gain access and commitment from groups already doing primary prevention of violence to support primary prevention of IPV and SV.

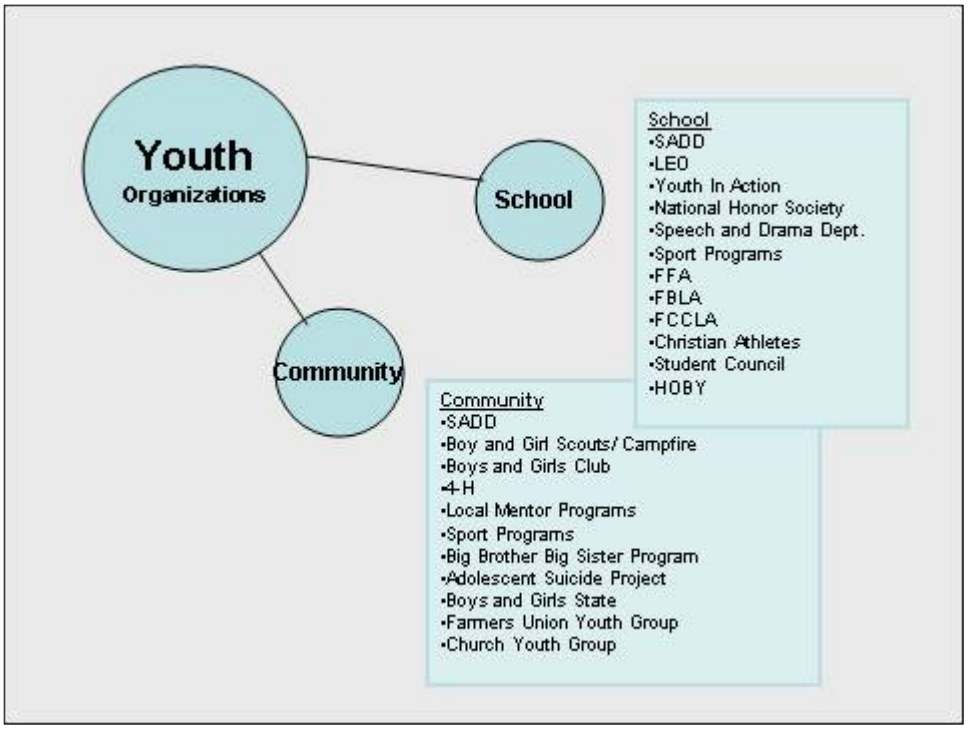



*Figure 2.7.* Youth Organization Resources

### *Law and Legal Resources*

Resources for prevention work may come from the arena of law and legal resources (see Figure 2.8). For instance, the juvenile court system and detention centers are resources for at-risk adolescents; school resource officers act as a liaison between school officials and law enforcement and other social service organizations. Not only do school resource officers act as

liaisons, they also implement crime prevention activities in the school**.** Many schools that do not employ a school resource officer use local police community officers to do what they can for education and support in the school settings**.** Tribal areas also have resources that may be beneficial for prevention efforts such as the Bureau of Indian Affairs, tribal court and tribal police. Potential partners to advocate for and assist with prevention efforts may come from associations in the legal field including the Trial Lawyers Association, the Police Training Academy, State Bar Association, Children's Alliance and the State's Attorney's offices. These organizations/associations have missions and previous projects that have assisted in a cause that promotes the well being of the people of ND.

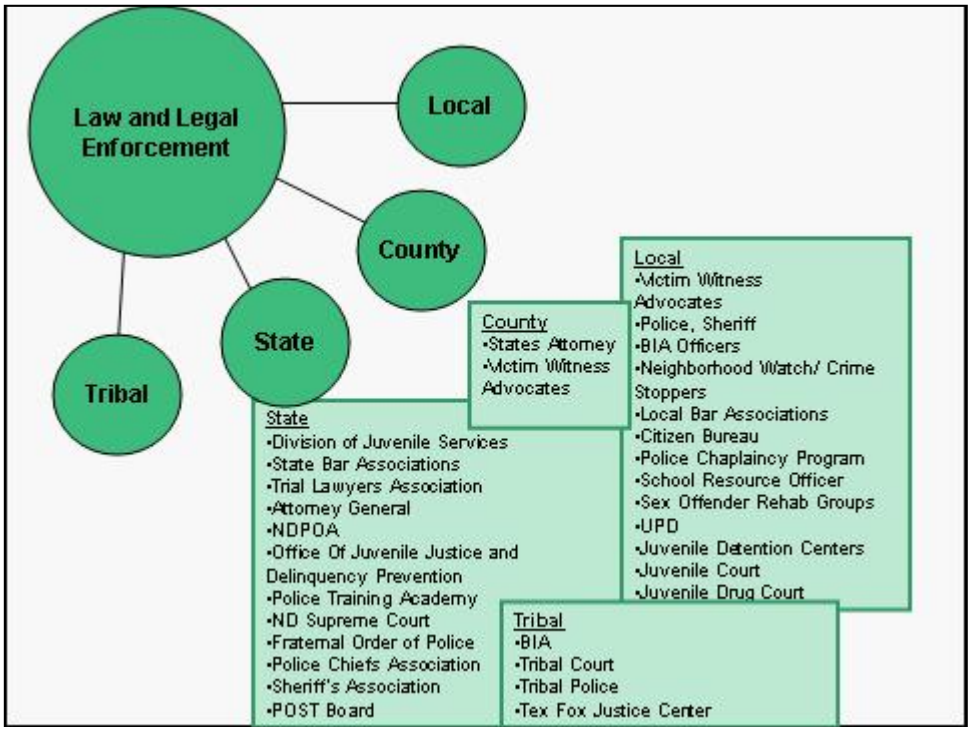



*Figure 2.8.* Law and Legal Resources

### *School Based Resources*

School based resources are very valuable to the efforts to prevent IPV and SV (see Figure 2.9). The programs already in place at certain schools focus on prevention of violence (Get Real about Violence) or educate children about healthy and respectful ways to treat other people (Character Counts). Schools may also have personnel or dedicated individuals who already have some sort of prevention or healthy living program in place. For instance, health educators teach lessons about negative effects of drugs and alcohol. At the state level, financial resources such as Title IX and Title IV could be potential future funding for prevention. Universities around the state have many resources to assist college-age students and may allow access to a potential population for future prevention efforts. For instance, The Rape and Abuse Crisis Center of Fargo-Moorhead (RACC) is working with North Dakota State University's (NDSU) athletic department to provide prevention programming and athletes at NDSU are participating in RACC's media campaigns.

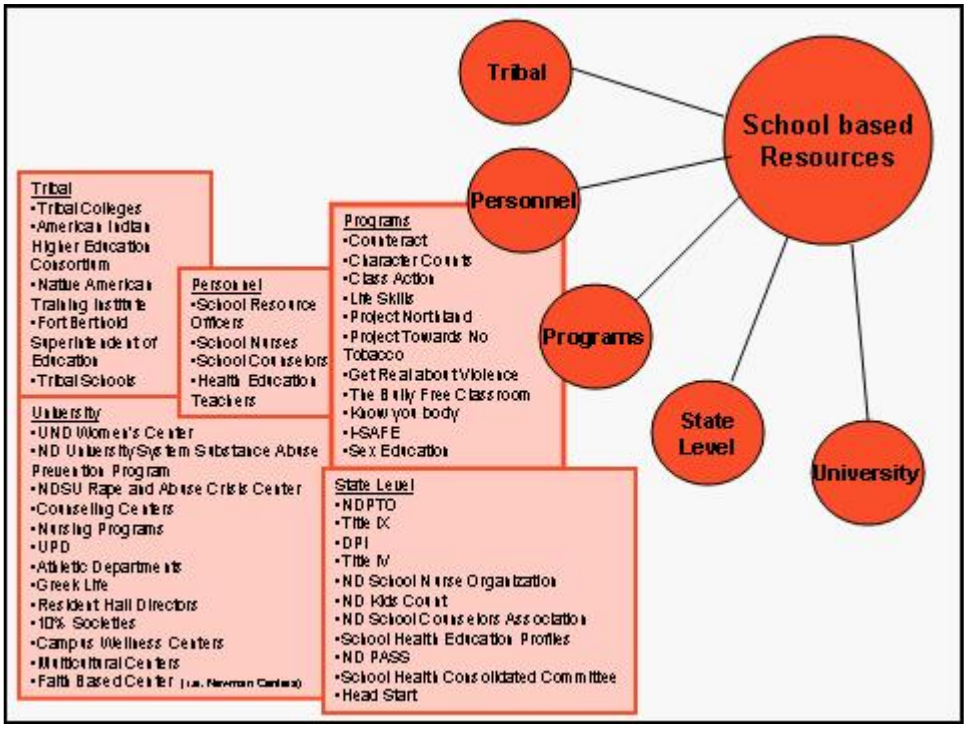



*Figure 2.9.* School Based Resources

### *Data Resources*

Data resources are very important in prevention efforts (see Figure 2.10). Data provides information to help the general public understand that IPV and SV are public health issues and more focus needs to be placed on the number of people being injured. Data sources are needed on different levels in order to accurately gauge how critical this problem is in our state. Data sources, such as information from NDCAWS/CASAND, can be used to determine how often women are seeking services for intimate partner and/or sexual violence. The prevalence of certain risk factors statewide and nationally can also be determined. For instance, the Behavioral Risk Factor Surveillance System (BRFSS) includes a question regarding past abuse, which is a risk factor for IPV and SV, while the Youth Risk Behavior Survey (YRBS) asks questions regarding bullying, sexual violence, and other risk taking behaviors that youth may have been engaged in at sometime in their lives. When trying to locate certain populations (by age, gender, race, etc), the U.S. Census can be an effective tool for analyzing the data gathered.

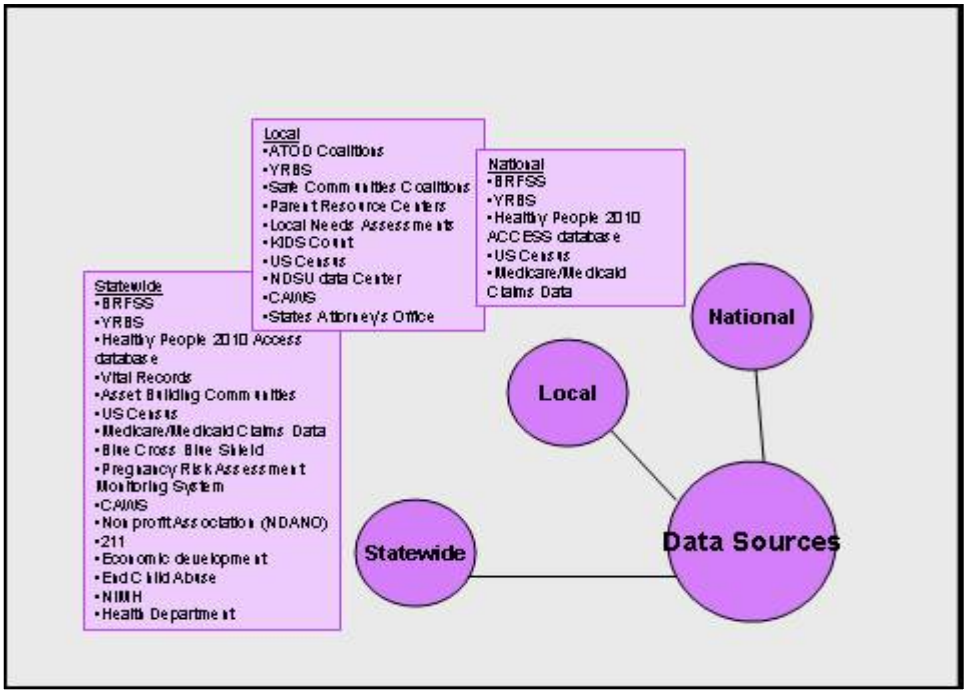



*Figure 2.10.* Data resources

### *Medical Resources*

Medical resources are distributed into three branches: statewide, tribal, and local medical resources (see Figure 2.11). The local medical resources such as clinics, hospitals, public health units and mental health providers could act as resources for disseminating information regarding healthy sexuality. There are many different potential avenues with these groups that may require training, education and information about IPV and SV primary prevention but the potential for this group to partner with is significant.

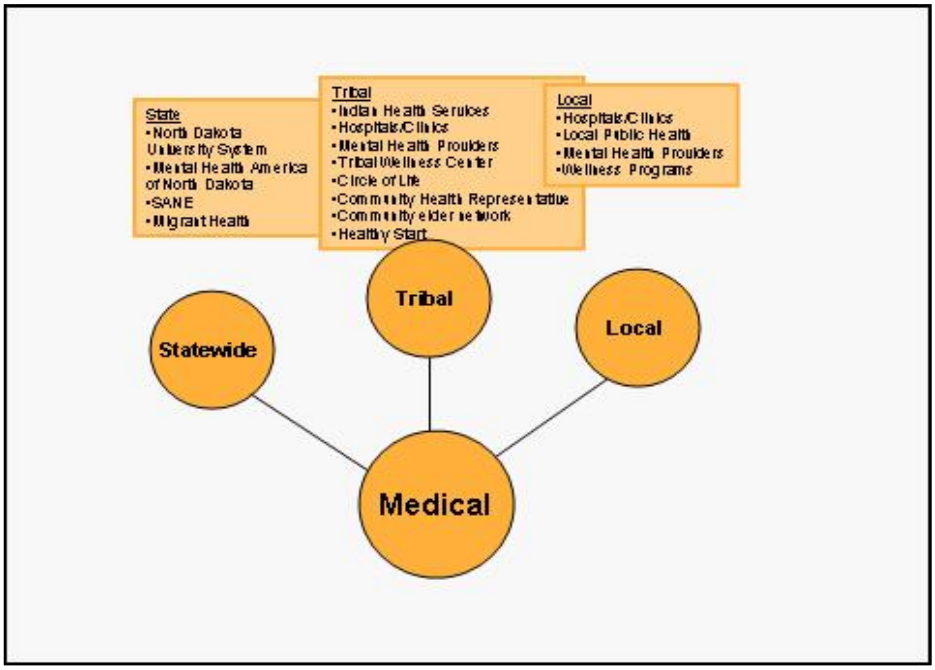



*Figure 2.11.* Medical resources

### *Community Organizations*

Community Organizations are critical resources for the prevention of IPV and SV in ND (see Figure 2.12). Many agencies, such as Lutheran Social Services and local domestic violence/rape crisis (DV/RC) agencies are already providing services to those who are affected by intimate partner and sexual violence. The DV/RC agencies across the state are currently planning and some are implementing prevention efforts. Abused Adult Resource Center in Bismarck, is implementing programs in the school system to promote healthy relationships and mutual respect. This is an example of a successful collaboration between the local agency and the school system. Local DV/RC agencies will be key collaborators throughout this primary prevention effort**.** Clubs and associations may be captive audiences for education of primary prevention for discussion and future projects. They may also become financial partners to allow the DV/RC agencies to carry out their work. Many are already incorporating antiviolence statements and projects in their missions, while others are mentoring youth as their mission through Junior Achievement, local mentoring programs, or local lunch buddy programs.

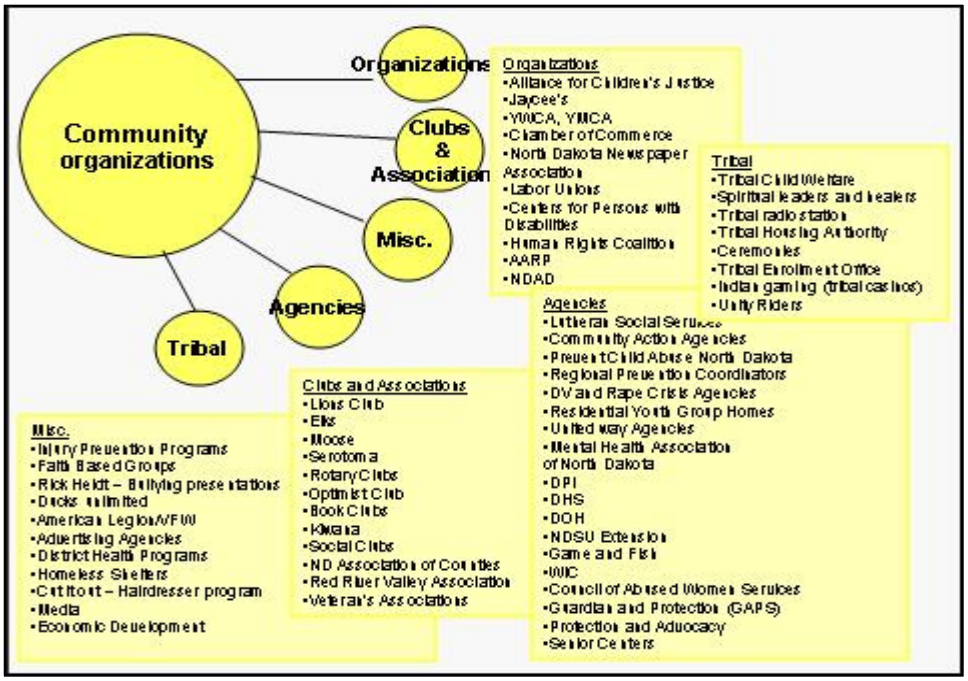



*Figure 2.12.* Community Organizations

### *Summary of IPV and SV Resources*

Currently, three federal programs – EMPOWER, DELTA, and RPE – provide resources for the prevention of IPV and SV in North Dakota. These combined resources support local DV/RC agencies and also help build the state infrastructure for prevention. In order to successfully implement the steps of GTO, these projects must partner with other state-wide and local entities to develop and institute violence prevention principles and strategies. Many other organizations at the state and local levels are interested in prevention, prevention of violence, and partnering to improve outcomes for North Dakota citizens. The challenge is to create an opportunity for organizations that are already strapped for resources to work together to better achieve their goals.

## Magnitude of Intimate Partner Violence

Understanding the magnitude of intimate partner violence (IPV), who experiences violence, and who commits violence in ND will assist in identifying target populations for primary prevention activities. The rate of violence varies by source; therefore, examining several different sources in order to determine the rate of victimization and perpetration is helpful. Typical reporting systems include the criminal justice system (i.e., Bureau of Justice Statistics, North Dakota Bureau of Criminal Investigation) and service providers (i.e. NDCAWS/CASAND). Another way to determine rate of intimate partner violence is through national research studies that contact people through random calling (i.e., National Violence Against Women Survey).

Another way to think about magnitude is the impact of the action, rather than its frequency. The impact might include physical and psychological trauma, social factors, economic factors, and other health factors. For example, in 2006, the National Network to End Domestic Violence (NNEDV) conducted a 24 hour census to collect an unduplicated count of adults and children who were served by local domestic violence programs. One service provider noted, "Today I had a client that had a weapon pulled on her when I was talking to her on the phone, so she had to hang up. When I called back, all phones had been disconnected." The impact of IPV within this family must affect all arenas of the family's functioning and each individual within the family. It also negatively affects the worker at the service provider's office.

### *Rates of IPV Victimization*

#### *IPV Rates as Reported through the Criminal Justice System*

One way to understand the magnitude of violence is to examine the rates as reported to the criminal justice system, such as law enforcement, the court and corrections. These rates provide helpful information but they only capture incidents that have been reported to the criminal justice system.

***Department of Justice-Bureau of Justice Statistics, National Crime Victimization Survey.*** The Bureau of Justice reports rates of domestic violence, which is defined as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Partners are defined as spouses or ex-spouses; boyfriends and girlfriends; ex-boyfriends and ex-girlfriends. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. A subunit, the Bureau of Justice Statistics, sponsors the National Crime Victimization Survey, which is a phone survey of US residents 12 years of age and older (NCVS, 2003).

In 2005 U.S. residents age 12 or older experienced an estimated 23 million violent and property victimizations, according to the National Crime Victimization Survey (NCVS).

*Bureau of Justice Statistics, Sept. 2006, NCJ 214644*

Twenty-two percent were crimes of violence. This same survey reported that one person out of every 1,000 persons age 12 or older experienced one rape or sexual assault and one assault with injury.

***Demographics***

Females are more likely than males to experience nonfatal intimate partner violence. Between 1993-2004, on average, nonfatal intimate partner victimizations represented 22% of nonfatal violent victimizations against females 12 and older and 3% of nonfatal violent victimizations against males age 12 and older. Of the total percent of homicides, intimate partners account for 30% of homicides of females and 5% of homicides of males.

***Bureau of Justice Statistics Intimate Partner Violence in US: Victim's Characteristics***

Victim/offender relationship in nonfatal violent victimizations, by victim and gender, 1993-2004

*Average annual rate per 1,000 age 12 or older*

| | Female | | Male | |
|---|---|---|---|---|
| Victim/offender relationship | Rate | Percent | Rate | Percent |
| Intimates | 6.4 | 22.0 | 1.1 | 2.9 |
| Other relatives | 2.2 | 7.7 | 1.4 | 3.7 |
| Friend/acquaintances | 10.6 | 36.4 | 13.3 | 33.8 |
| Stranger | 9.9 | 33.9 | 23.5 | 59.6 |

Homicide victim/offender relationship by victim gender, 1976-2004

*Percent of homicide victims by gender*

| Victim/Offender Relationship | Female | Male |
|---|---|---|
| Intimate | 30.1 | 5.3 |
| Other-Family | 11.7 | 6.7 |
| Acquaintance/Known | 21.8 | 35.5 |
| Stranger | 8.8 | 15.5 |
| Undetermined | 27.7 | 37.1 |
| Total | 100 | 100 |

*Bureau of Justice Statistics - www.ojp.usdoj.gov/bjs/*

The Bureau of Justice reports intimate partner violence by gender, income, and age. According to the Bureau of Justice Statistics (2004), people who have lower annual income levels experience the highest rate of IPV. In their study, BJS found that 18% of females who earned less than $7,500 were victims of IPV. Ten percent of females in the $7,500 to $24,999 category experienced IPV. Only 2.8% of the women in the $50,000+ category experienced IPV. Females in the oldest (50+) and in the youngest (12-15) age categories were at low risk of IPV during the years of 1993-2003. Women ages 25-34 had the highest risk.

***ND Bureau of Criminal Investigation (ND BCI).*** The ND BCI reports define domestic violence as physical harm, bodily injury, sexual activity compelled by physical force, assault, or the infliction of fear of imminent physical harm, bodily injury, sexual activity compelled by physical force, or assault, not committed in self-defense, on the complaining family or household members. All police jurisdictions in ND submit data to the report. In 2001, intimate partner violence (IPV) or domestic violence accounted for 48% of all physical assault cases in ND

(Stenehjem, 2002). Fifty one percent (51%) of homicide victims from 1978-2005 resulted from domestic violence (Stenehjem, 2005). There have been 158 domestic violence victims of homicide since 1978 (Stenehjem, 2005); 37 were slain during multiple homicides; all perpetrators have been male.

| Year | Domestic | Non-Domestic | No Assailant Identified | Homicide Total |
|---|---|---|---|---|
| 1978 | 5 | 4 | 1 | 10 |
| 1979 | 4 | 9 | | 13 |
| 1980 | 7 | 6 | | 13 |
| 1981 | 8 | 7 | 2 | 17 |
| 1982 | 4 | 1 | 1 | 6 |
| 1983 | 7 | 10 | 1 | 18 |
| 1984 | 10 | 2 | | 12 |
| 1985 | 2 | 7 | | 9 |
| 1986 | 5 | 4 | 1 | 10 |
| 1987 | 4 | 7 | 1 | 12 |
| 1988 | 6 | 5 | 1 | 12 |
| 1989 | 5 | 3 | 1 | 9 |
| 1990 | 5 | 3 | | 8 |
| 1991 | 5 | 4 | 2 | 11 |
| 1992 | 11 | 4 | | 15 |
| 1993 | 11 | 11 | | 22 |
| 1994 | 4 | 1 | 1 | 6 |
| 1995 | 3 | 6 | | 9 |
| 1996 | 7 | 5 | | 12 |
| 1997 | 2 | 8 | | 10 |
| 1998 | 5 | 2 | | 7 |
| 1999 | 6 | 6 | | 12 |
| 2000 | 6 | 1 | 1 | 8 |
| 2001 | 2 | 5 | 2 | 9 |
| 2002 | 4 | 1 | 1 | 6 |
| 2003 | 8 | 4 | | 12 |
| 2004 | 6 | 4 | | 10 |
| 2005 | 6 | 6 | 1 | 13 |
| Total 1978-2005 | 158 | 136 | 17 | 311 |

*Stenehjem, 2005*

***Demographics.*** The ND BCI reports demographic information on gender and race. Seventy percent of the 2,167 victims of domestic violence reported through the Uniform Crime Reports (UCR) were female and 30% were male (Stenehjem, 2001). According to Stenehjem (2002), victims of domestic violence varied by race: Asian (N=9), Black (N=65), American Indian (N=286) and White (N=1737).

### *IPV Rates as Reported by NDCAWS/CASAND*

NDCAWS/CASAND compiles statistics on victimization each year that are reported by the 21 DV/RC agencies throughout the state. All data is victim based or reported when the victim

receives services for a domestic violence or sexual assault incident. In 2005, 4,370 new or "unduplicated" domestic victims were served by the 19 participating programs in calendar year 2005. In this case, unduplicated counts mean that a person who identifies themselves to an agency will be counted once by that agency during that year. They may have also been counted in another year or by another agency. Eight hundred and seventy six (46%) had been clients in a previous year. Thirty-six percent made phone contact only. Ninety-four percent (N=4,127) were female. More were in the 30-44 age group (see Table 2.9). This group is slightly older than the most common age groups in national surveys. Fourteen percent self reported a disability; as a rule, they were not asked if they had a disability so this number may be underreported.

Table 2.9. *Age of Victims*

| Age of Victims | N | % |
|---|---|---|
| 0-12 Years | 0 | 0 |
| 13-17 Years | 80 | 2 |
| 18-29 Years | 1,88 | 39 |
| 30-44 Years | 1,78 | 43 |
| 45-64 Years | 663 | 15 |
| 65 & Older | 61 | 1 |
| Unknown | 0 | 0 |
| Total | 4,70 | 100 |

Seventy-two percent were Caucasian (see Table 2.10). The rate of interpersonal violence did not vary by race in recent national surveys; in ND the percent of people who experience IPV is greater for women who are American Indian.

Table 2.10. *Reported Violence by Race*

| National Origin | N | % |
|---|---|---|
| Caucasian | 3,152 | 72 |
| American Indian/Alaskan Native | 905 | 21 |
| African American/Black | 42 | 1 |
| Asian/Pacific Islander | 10 | 0 |
| Hispanic | 100 | 2 |
| Other | 14 | 0 |
| Unknown | 147 | 3 |
| Total | 4,370 | 100 |

Most victims lived in a city with a population over 35,000 population or a city or location with a population under 10,000 (see Table 2.11).

Table 2.11. *Size of Victim's Community*

| Size of Community | N | % |
|---|---|---|
| Rural and Remote Location | 147 | 3 |
| Town under 500 population | 263 | 6 |
| Town 500 to 1,500 pop. | 306 | 7 |
| Town 1,500 to 5,000 pop. | 320 | 7 |
| City 5,000 to 10,000 pop. | 330 | 8 |
| City 10,000 to 35,000 pop. | 639 | 15 |

| | | |
|---|---|---|
| City over 35,000 pop. | 2,129 | 49 |
| Tribal | 235 | 5 |
| Underserved Urban | 1 | 0 |
| Total | 4,370 | 100 |

The most common length of exposure to a violent relationship was 1-5 years; 189 had experienced over 20 years of violence (see Table 2.12). Thirty-nine percent of victims were employed, the same employment rate as that of abusers.

Table 2.12. *Length of Exposure to Violent Relationships*

| Exposure Length | N | % |
|---|---|---|
| Under 1 Year | 762 | 17 |
| 1-5 Years | 1,956 | 45 |
| 6-10 Years | 460 | 11 |
| 11-20 Years | 338 | 8 |
| Over 20 Years | 189 | 4 |
| Unknown | 665 | 15 |
| Total | 4,370 | 100 |

### *IPV Rates as Identified by National Surveys*

***National Violence Against Women (NVAW) Survey.*** The National Violence Against Women (NVAW) survey, sponsored by the National Institute of Justice and the Centers for Disease Control and Prevention, is a national telephone survey conducted from November 1995 to May 1996. Data were collected through interviews with both women and men, thus providing comparable data on women's and men's experiences with violent victimization (Tjaden & Thoennes, 2001).

### *Demographics*

Results from the National Violence Against Women Survey (NVAWS) reported that nearly 25 % of women and 7 % of men said they were raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some time in their lifetime.

Persons Physically Assaulted Lifetime and Previous 12 months

| Physical Assault timeframe | Women (*n*= 8,000) Percent | Men (*n*= 8,000) Percent | Women (100,697,000) Number | Men (92,748,000) Number |
|---|---|---|---|---|
| Physically assaulted in lifetime | 22.1 | 7.4 | 22,254,037 | 6,863,352 |
| Physically assaulted in previous 12 months | 1.3 | 0.9 | 1,309,061 | 834,732 |

*Tjaden & Thoennes, 2001*

Eighty-five percent of IPV victims were women. Finally, 39% of the women in the study who were physical assault victims reported being injured during their most recent attack, compared to 24% of men.

| Persons Injured During Most Recent Assault | | |
|---|---|---|
| Was the victim injured? | Women (*n*= 1,862) Percent | Men (*n*= 2,962) Percent |
| Yes | 39.0 | 24.8 |
| No | 61.0 | 75.2 |

*Note: To review the complete report visit* http://www.ncjrs.gov/pdffiles1/nij/181867.pdf

According to the NVAW survey, females (25.5%) were more likely to be a victim of intimate partner violence than males (7.9%). Thirty-eight percent of women who were American Indian were victimized sometime in their life and 24.8% of women who were white were victimized at some point in their life. Young women and those below the poverty line are disproportionately represented in the group who were victims of IPV. (Tjaden and Thoennes, 2001)

***National Network to End Domestic Violence.*** The National Network to End Domestic Violence (NNEDV) conducted a point in time survey in 2006. Although it does undercount the rate of violence since only 62% of the domestic violence programs in America participated, it does highlight the tremendous need.

In November 2006, 1,243 out of 2,016 identified local domestic violence programs across the United States participated in the first National Census of Domestic Violence Services (NCDVS). Designed to address the safety and confidentiality needs of victims, this Census collected an unduplicated, non-invasive count of adults and children who received critical services from local domestic violence programs during the 24-hour survey period. Since approximately 62% of local domestic violence programs in the U.S. participated, this Census provides a powerful glimpse but remains an undercount of the actual number of victims who sought and received services from local domestic violence programs nationwide in a 24-hour period.

During the survey period, **47,864 adults and children requested and received services** from the 1,243 local domestic violence programs that were able to participate in the Census. Since this is 62% of local domestic violence programs in the U.S., it does not represent the total number of victims seeking services nationwide. Participating programs reported that **5,157 requests for services from adults and children went unmet** due to a lack of sufficient resources. Also, during the survey period participating programs answered 16,644 hotline calls from victims and their loved ones, and provided prevention and education sessions to 40,215 members of the community.

On the survey day in November 2006, **47,864 adults and children were served** by 1,243 local domestic violence programs across the United States. During the 24-hour survey period more than 22,277 victims of domestic violence received housing services from a domestic violence program, either in emergency shelters or transitional housing. An additional 25,587 victims received non-residential services such as support groups, children's counseling, and legal advocacy.

- 14,344 adults and children found refuge in emergency domestic violence shelters.
- 7,933 adults and children were living in transitional housing programs, designed specifically for domestic violence survivors.
- 25,587 adults and children sought non-residential advocacy and services such as individual counseling, legal advocacy, and children's support groups.

During the survey period, participating programs reported that local and state hotline advocates answered 15,431 calls and the National Domestic Violence Hotline answered 1,213 calls. In total, advocates responded to almost 17,000 hotline calls in the 24-hour survey period, which equals **more than 11 hotline calls every minute**.

http://www.nnedv.org/census/DVCounts2006/DVCounts06_Report.pdf

***Youth Risk Behavior Survey (YRBS).*** The ***Youth Risk Behavior Surveillance System*** monitors six categories of priority health-risk behaviors among youth and young adults at the national, state, and local levels. Surveys are administered every other year to youth in grades 7-9. According to the YRBS in 2005, out of those who experienced dating violence, 9.3% were female and 9.0% were male. Of those who were forced to have sexual intercourse, 10.8% were female and 4.2% were male.

***2005 North Dakota High School (Grades 9-12) Youth Risk Behavior Surveillance System Summary of the National, Statewide, Regional, and Urban Vs. Rural Results***

| Question | 2003 CDC Statewide Results | 2005 CDC Statewide Results | 2005 CDC National Results | Region 1 Williston | Region 2 Minot | Region 3 Devils Lake | Region 4 Grand Forks | Region 5 Fargo | Region 6 Jamestown | Region 7 Bismarck | Region 8 Dickinson | Urban | Rural |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Students who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months* | 9.8 | 8.8 | 9.2 | 9.5 | 10.0 | 10.0 | 7.6 | 10.1 | 9.5 | 9.8 | 8.4 | 9.8 | 9.5 |
| Students who have ever been physically forced to have sexual intercourse when they did not want to ** | 8.80 | 7.10 | 7.50 | 8.90 | 8.40 | 7.70 | 8.20 | 7.60 | 8.40 | 7.60 | 7.80 | 8.60 | 7.40 |

*ND Question 17, CDC Question 21
** ND Question 18, CDC Question 22s
Urban is defined as 1000+ students in grades K-12
Rural is defined as less than 1000 students in grades K-12

*Youth Risk Behavior Surveillance System Summary*

### *Rates of IPV Perpetration*

If rates of victimization are difficult to find, rates of perpetration are even more difficult to identify. Rates reported to the criminal justice system are not congruent with the rates of reported offenses. Programs in the community that serve people identified as perpetrators serve a unique portion of the population of perpetrators. Although they have problems, these sources of data do provide information regarding perpetration, rates of perpetration, and potential areas for prevention programming to target. For instance, the ND BCI reports that offenders of domestic violence were predominately male (73%) (Stenehjem, 2001). Stenehjem (2002) stated that in ND, white males accounted for 57% of domestic violence perpetrators. All perpetrators of the 158 domestic violence victims of homicide since 1978 have been male (Stenehjem, 2005). According to NDCAWS/CASAND data provided by victims, abusers were most likely to be a spouse or former partner (see Table 2.13).

Table 2.13. *Relationship between the Abuser and the Victim*

| Relationship | N | % |
|---|---|---|
| Spouse | 1,429 | 32.7 |
| Former Spouse | 354 | 8.1 |
| Cohabitating Partner | 658 | 15.1 |
| Partner | 467 | 10.7 |
| Former Partner | 918 | 21.0 |
| Family Member/Relative | 336 | 7.7 |
| Roommate | 172 | 3.9 |
| Other | 8 | 0.2 |
| Unknown | 28 | 0.6 |
| Total | 4,370 | 100.0 |

Other sources of data include programs that serve perpetrators, such as the North Dakota's Batterer's Treatment Forum, which includes treatment programs in Grand Forks, Bismarck, and Dickinson, in conjunction with their domestic violence agencies. (Treatment programs for perpetrators of sexual violence are operated through the regional human service centers.) The Community Violence Intervention Center in Grand Forks, in addition to hosting a treatment group for men who batter, also collects other information regarding perpetration (see Table 2.14). This report tracks the age range, gender, and race.

Table 2.14. *Rates of Domestic Violence in Grand Forks, North Dakota, 2004, 2005, and 2006*

| **General Domestic Violence** | 2004 | 2005 | 2006 |
|---|---|---|---|
| Number of law enforcement responses to domestic incidents | 969 | 1035 | 947 |
| **Day** of week with most law enforcement responses | Sunday | Sunday | Sunday |
| Number incidents with elements of **stalking**: intimate partners | 69 | 46 | 61 |
| Number incidents with elements of **stalking**: non-intimates | 14 | 19 | 10 |
| ***Intimate Partner Violence*** (includes past and present partners) | | | |

| | | | |
|---|---|---|---|
| Number of law enforcement incidents between intimate partners | 763 | 843 | 695 |
| **Protection Orders** | | | |
| Number **protection orders** obtained with CVIC assistance | 112 | 89 | 70 |
| Number protection order **violations** officers responded to | 48 | 80 | 38 |
| **Demographics on Law Enforcement Reports** | | | |
| **Age** range of victims | 14—63 | 16—70 | 15—71 |
| **Age** range of suspects (only track adult suspects) | 18—73 | 18—71 | 18-68 |
| Average age of victims | 31 | 31 | 31 |
| Average age of suspects | 32 | 32 | 31 |
| **Male** suspects | 71% | 73% | 70% |
| **Female** suspects | 16% | 14% | 20% |
| Both genders listed as victims and/or suspects | 13% | 13% | 10% |
| **Female** victims | 71% | 73% | 72% |
| **Male** victims | 16% | 14% | 18% |
| **Race** of Suspects & Victims in 2006: | • 0.4% & 0.6% Asian<br>• 8.2% & 4.3% African American<br>• 7.0% & 6.7% Hispanic | • 11.3% & 11.8% Native American<br>• 4.3% & 2.9% Other/Unknown<br>• 68.9% & 72.7% White/Caucasian | |

**Children in Law Enforcement Reports**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Child** in common between partners in incidents | 216 | 28% | 267 | 32% | 238 | 34% |
| **Child** witnessed incident | 133 | 17% | 120 | 14% | 96 | 14% |
| **960** child abuse & neglect report by law enforcement | 58 | 44% | 73 | 61% | 60 | 63% |

**Other Circumstances in Law Enforcement Reports**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Alcohol** involved | | 33% | | 38% | | 42% |
| **Strangulation** noted in incident report | 40 | 5% | 34 | 4% | 43 | 6% |

**Arrests**

| | | | |
|---|---|---|---|
| **Arrest** rate (Some cases forwarded to another jurisdiction) | 23% | 26% | 27% |
| **Dual** arrests | 2 | 4 | 4 |
| Protection Order Violation Arrest rate (ALL Relationships) | 29% | 35% | 35% |
| Cases sent to **State's Attorney's Office** (Arrests, Affidavits of Probable Cause or Request for Review) | 234 | 277 | 233 |

**Grand Forks County - Prosecution and Sentencing**

| | | | |
|---|---|---|---|
| Number of charges with **convictions** (General Domestic Violence --includes ALL relationships) | 117/160<br>73% | 133/205<br>62% | 198/245<br>81% |
| Domestic Violence **Offender Treatment** ordered during sentencing | 34/117<br>29% | 27/133<br>20% | 41/198<br>21% |

*General domestic violence includes intimate partner violence and violence among other family members. Jurisdictions tracked: Grand Forks Police Department, Grand Forks County Sheriff's Office, and University of North Dakota Police Department, ND*

### *Rates of Intimate Partner Violence and American Indians*

Perry (2004) (*A BJS Statistical Profile, 1992-2002* American Indians and Crime By Steven W. Perry *BJS Statistician* December 2004, NCJ 203097) reported high rates of violence experienced by persons who are American Indian.

In North Dakota (ND), of the 642,000 residents, 31,000 (5%) are American Indian. Almost 60% of American Indians in ND live on one of the four reservations and 41% percent (13,000) of American Indians in ND are under the age of 20. Although Native Americans comprise only five percent of the population, violent victimization occurs at an alarming rate both on and off the reservations. In the first six months of 2005, of the 2,400 domestic violence victims statewide, 20% were Native American. More specifically, two domestic violence programs located on reservations provided services for 123 (98%) Native American victims; crimes perpetrated on these victims were committed primarily by Native Americans (97%). In addition, over 50% of victims and perpetrators served by a domestic violence program bordering one of the reservations were Native American. There are many challenges and obstacles that we are facing today in Indian Country in North Dakota when trying to address domestic violence and sexual assault.

- Lack of codes, laws, and philosophy statements that incorporate tribal values and hesitancy to utilize sovereign nation status and powers within tribal courts, tribal law enforcement, tribal prosecutors and social services.
- Inadequate training and resources for the investigation and prosecution of sexual crimes.
- Low percentage of arrests for domestic and sexual violent crimes and lack of enforcement and honoring of national Full, Faith and Credit Provisions.
- Inadequate resources to address the needs of underserved Native American women of the Standing Rock Nation and Trenton Indian Service Area.
- Lack of education and awareness campaigns and programs on the impact of violence within the tribal communities and the impact of historical violence on Native people.

*Excerpt from First Nations Women's Alliance Tribal Coalition Grant*

### *The Impact of IPV on Individuals, Families, and Communities*

#### *National Information*

The impact of IPV includes both the numbers of events and what the event itself means. This might be an impact to an individual, their family, and the broader community. Both perpetrators and victims experience impact. In *Costs of Intimate Partner Violence Against Women in the United States* (Centers for Disease Control and Prevention, 2003), the costs of IPV are described in detail, based on data collected in 1995. Most other reports of cost are based on this data also. Costs include individual costs, such as pain, health care costs and lost income (U.S. Department of Justice, 1996; Bugarin, 2002). Organizations experience costs such as health care, lost work days, reduced capacity of employees (*The Corporate Cost of Domestic Violence,* American Institute on Domestic Violence, www.aidv-usa.com).

**Economics**
The costs of domestic violence are estimated to exceed $8 billion each year. Costs include $5.8 billion for medical and mental health care and $2.5 billion in lost productivity.
According to the CDC, health care costs associated with each incident of domestic violence averaged $948 per woman.

One third of CEOs believe domestic violence has a negative impact on their bottom lines.
74% of employed battered women report having been harassed by their partner while they were at work.

**Health Impacts**
Girls who reported being abused by dating partners were:

- More than *twice as likely* as non-abused girls to report smoking, drinking, and using illegal drugs.
- Almost *three times as likely* to engage in bingeing and purging.
- *Six to nine times* as likely to contemplate or attempt suicide.

In addition, available data indicate that abused women are at an increased risk for developing depression, PTSD, and other mental health problems.

In 1994, 37% of all women who sought care in hospital ER for violence-related injuries were injured by a partner or former partner.

**Impact on other social issues**
Child abuse and maltreatment:

- 50% of men who frequently assault their wives frequently assault their children.

The U.S. Advisory Board on Child Abuse and Neglect suggests that domestic violence may be the single major precursor to child abuse and neglect fatalities in this country.

*Centers for Disease Control and Prevention, 2003*

***Summary***

Data regarding rates of IPV are suspect. According to the CDC, many IPV incidents nationally are not reported to the police. About 20% of IPV rapes or sexual assaults, 25% of physical assaults, and 50% of stalking directed toward women are reported nationally. Even fewer IPV incidents against men are reported (Tjaden and Thoennes, 2000a). Data is even less available for perpetrators and groups such as women who are American Indian and living on tribal lands.

Even with the difficulties with obtaining accurate data, it is clear that intimate partner violence is a key issue. In ND over 2000 victims contact domestic violence agencies annually. Most victims are young adult women to middle age women, the most common ages range from 25 and 44. People living in lower income had higher rates of IPV. The numbers of intimate partner violence are higher in the more populated areas, such as Cass County. Although not

calculated, one might speculate that the rates of victimization by IPV are highest in communities that have a younger population and among women who are lower income. Of the available data, white men were the majority of the perpetrators.

Not only is the number of people affected important, but the impact on the individuals, their families, and the community is also critical. Nationally, it costs 8 million dollars yearly in medical costs and loss of productively for victims. Those who are a victim engage in risky and self harm behavior more often.

## Magnitude of Sexual Violence

Sexual violence (SV) is a serious problem impacting millions of lives across the nation. However, the true magnitude of SV is difficult to conclude since data collection is inconsistent and definitions of sexual violence differ. According to the United States Department of Justice Report (2003), only 39% of rapes and sexual assaults are reported to law enforcement officials. Therefore, understanding the different definitions of SV is important when looking at a variety of data sources in order to get the most accurate picture of the magnitude of sexual violence. These data sources include data reported through the criminal justice system (Uniform Crime Report), social service agencies (NDCAWS/CASAND Data), and national and statewide surveys (National Violence Against Women Survey and Youth Risk Behavioral Survey).

### *Rates of SV Victimization*

#### *SV Rates as Reported through the Criminal Justice System*

According to the Uniform Crime Report's definition of rape in ND, only women are listed as being a victim; males are not included. The number of forcible rapes in ND increased from 2005 (N=146) to 2006 (N=184) by 26% (Stenehjem, 2006). The number of forcible rapes is currently the highest in the last 10 years (see Figure 2.13). For every 100,000 women in ND, 57.9 were forcibly raped, which is an increase from 2005 (49.5) (Stenehjem, 2006). There was a downward, although variable, trend until 2006, when a sharp jump occurred.

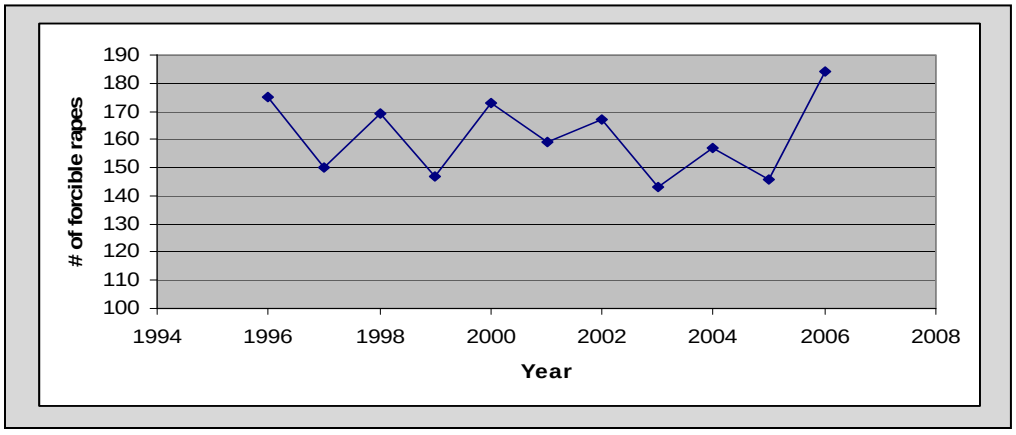



*Figure 2.13*. Forcible Rapes

### *SV Rates as Reported by NDCAWS/CASAND*

NDCAWS/CASAND annually compiles statistics from 19 DV/RC agencies in Bismarck, Bottineau, Devil Lakes, Dickinson, Ellendale, Fargo, Fort Berthold, Spirit Lake, Grafton, Grand Forks, Jamestown, Mclean County, Mercer County, Minot, Ransom County, Stanley, Valley City, Wahpeton, and Williston. This data is collected from victims while they are receiving services from rape crisis and domestic violence agencies. According to this data, in 2006, 966 primary sexual assault victims were served across the 19 participating programs. Eighty-nine percent (N=858) were female. The majority of victims (31%) were between the ages of 18 and 29 (see Table 2.15).

Table 2.15. *Age of Victim*

| | N | % |
|---|---|---|
| 0-12 Years | 208 | 22% |
| 13-17 Years | 202 | 21% |
| 18-29 Years | 301 | 31% |
| 30-44 Years | 175 | 18% |
| 45-64 Years | 75 | 8% |
| 65 & Older | 4 | 0% |
| Unknown | 1 | 0% |
| TOTAL | 966 | 100% |

Seventy-six percent were Caucasian (see Table 2.16). A higher percent of people who are American Indian were served than the percent of American Indians represented in the general population.

Table 2.16. *Race and Ethnicity*

| | N | % |
|---|---|---|
| Caucasian | 732 | 76 |
| American Indian/Alaskan Native | 133 | 14 |
| African American/Black | 19 | 2 |
| Asian/ Pacific Islander | 6 | .5 |
| Hispanic | 22 | 2 |
| Other | 6 | .5 |
| Unknown | 48 | 5 |
| TOTAL | 966 | 100 |

### *National and Statewide Surveys*

***National Violence Against Women Survey.*** The National Violence against Women Survey was a random telephone interview conducted in 1995-1996 with adult women in the United States (Tjaden & Thoennes, 2006). About 8,000 men and women were interviewed during this process. Findings indicated that 17.6% of females and 3% of males were raped at

some point in their life. 1 in 6 females and 1 in 33 males were raped at some point in their life. These statistics also included attempted rape.

Kilpatrick and Ruggiero (2003) estimated the lifetime rate of rape in ND to be 13.2% of women or 1 in 8 women in North Dakota. This ratio (1 in 8) was extrapolated from national data using an estimation formula.

***Demographics.*** From the data in the NVAWS, 99.6% of females and 85.2% of males were raped by a male. Twenty-nine percent of females and 16.6% of males were victims between the ages of 18-24 years old. The majority of females (54%) and males (71%) indicated they were raped before the age of 18.

***Nationally Administered State Specific Surveys.*** The WEAV (Working in Education to End Violence) Project administered surveys to 10% of all college students from 11 North Dakota Colleges and Universities (Steiner & Kraft, 2004). Forty-one percent (N=96) of females and 22% (N=19) of males indicated they had experienced at least one incident of unwanted sexual activity. This includes intercourse, oral sex, or other sexual contact. Forty-four percent of this unwanted sexual contact occurred at parties and 48% occurred at a private residence, typically the victim's or the perpetrators.

The YRBS administered every other year to a sample of high school students, contains two questions directly related to sexual violence. Seven percent of high school students were physically forced to have sexual intercourse and 8.8% of ND high school students were hit, slapped or physically hurt on purpose by their boyfriend or girlfriend. Females were more likely to be forced to have sexual intercourse and the percentage of females increased with grade level. Males (9.0%) had a higher percentage affected by dating violence than females (8.5%). The percent of both males and females affected by dating violence increased with grade level.

### *Rates of SV Perpetration*

According to the ND UCR, 38 people were arrested for forcible rape in 2006. All were male and the majority were Caucasian (N=28; African American N=4; Native American N= 7). Based on data from NDCAWS/CASAND, which is collected from victims, the perpetrator is most often a friend/acquaintance/date (see Table 2.17). The next most common categories are stranger and spouse/cohabiting adult.

Table 2.17. *Assailant Relationship to Victim*

| | N | % |
|---|---|---|
| Parent | 8 | 2% |
| Stepparent | 11 | 3% |
| Cohabitating Adult in Parental Role | 1 | 0% |
| Sibling | 5 | 1% |
| Other Relative | 22 | 5% |
| Person in Position of Authority | 15 | 3% |
| Friend/Acquaintance/Date | 189 | 43% |
| Spouse/Cohabitating Adult | 59 | 14% |

| | | |
|---|---|---|
| Coworker/Employer | 22 | 5% |
| Therapist/Counselor | 0 | 0% |
| Other Professional | 3 | 1% |
| Stranger | 63 | 14% |
| Information Unknown | 37 | 9% |

### *Impact on Individuals, Families, and Communities*

#### *Regional Information*

No data is available regarding the cost of sexual violence in ND. Minnesota recently published *Costs of Sexual Violence in Minnesota* (Miller, Taylor, & Sheppard, 2007). Clearly the cost is high, both for victims and perpetrators.

> Sexual assault in Minnesota cost almost $8 billion in 2005, or $1,540 per resident. The largest cost was due to the pain, suffering, and quality of life losses of victims and their families, and related breakdowns in their lives and relationships. Medical care, mental health care, victim work loss, sexually transmitted diseases, unplanned pregnancy, suicidal acts, substance abuse, and victim services cost $1.3 billion. Criminal justice and perpetrator treatment cost $130.5 million. These estimates are a fraction of the true costs. For example, they exclude (1) the costs of crimes committed by people whose experiences of victimization contributed to their criminal behavior; (2) costs of family and relationship problems that arise when someone perpetrates sexual violence; (3) re-victimization during the disclosure and/or investigation process; (4) costs to those who are mistakenly suspected of committing sexual offenses; (5) costs of personal and community protection like alarms and security services; and (6) heightened fear and mistrust in neighborhoods, schools, workplaces, and other community settings. In Fiscal Year (FY) 2006, the state government spent $130.5 million on people known to have perpetrated sexual violence, while spending $90.5 million on those who were assaulted. Funding for offender treatment and supervision recently was boosted, but victim services do not reach every county. Nearly $823,000 of federal funds were spent changing societal norms to prevent sexual assault.
>
> *Miller, Taylor, and Sheppard, 2007, p. 4*

### Summary

Kilpatrick et al (2003) estimated that one in every eight females will be raped at some point in their lifetime. Victims are most likely to experience sexual violence between the ages of 18 and 29. Forty percent of college age females and 22% of males indicated they experienced unwanted sexual contact. Victims are overwhelmingly women and perpetrators are more likely male. However, perpetrator data is limited for sexual violence. All of the persons arrested for sexual assault in ND were male and the majority were Caucasian. Victims who sought services at NDCAWS/CASAND were more likely Caucasian (76%), although persons who are Native Americans were overrepresented (14%).

## Risk and Protective Factors

According to the CDC's National Center for Injury Prevention and Control (NCIPC), certain groups are at greater risk for IPV and SV victimization or perpetration than others. Determining what may contribute to increased risk for some groups assists in identifying targets for prevention activities. Risk factors are considered to be those variables that are correlated with greater risk. They are associated with a greater likelihood of victimization or perpetration; they are not necessarily direct causes of violence but may be co-occurring (Heise and Garcia-Moreno, 2002).

Some risk factors for IPV and SV victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another. For example, childhood physical or sexual victimization is a risk factor for future perpetration and victimization **(http://www.cdc.gov/ncipc/factsheets/ipvfacts.htm**). The picture is even more complex for protective factors. Little research exists to support protective factors. For instance, Jankowski, Leitenberg, Henning, and Coffey (2002) examined parental support as a buffer for children who had been victimized and found no impact.

### *Risk Factors for Intimate Partner and Sexual Violence*

An iterative process was used to identify risk factors for intimate partner and sexual violence in North Dakota. The ND Intimate Partner and Sexual Violence State Prevention Team (SPT) brainstormed an initial list of risk factors after hearing a presentation based on a preliminary review of the literature. That list was integrated with the results of local entities' brainstorming regarding IPV and SV risk factors. Results of an in-depth review of the literature were used to further refine the list of risk factors. Risk factors for both perpetration and victimization were examined. Factors related to victimization include early childhood experiences, especially multiple victimization for females (see Table 2.18).

Research has identified more risk factors for perpetration than for victimization. Men who experience violence as a child, either witnessing parental violence or experiencing violence (physical and sexual), are more likely to perpetrate in adulthood (see Table 2.19). Males who hold traditional gender norms are more likely to engage in both sexual and physical violence. The two factors together are even more powerful predictors of male perpetration. Bullying also has links with adult partner violence. Those who were violent in middle school are more likely to be violent towards a partner in young adulthood.

Five of the risk factors determined to be particularly relevant because of the body of research supporting them and their relevance to ND, early childhood experiences, bullying, community characteristics, substance use, and gender role attitudes, are further expanded.

Table 2.18. *Risk Factors for Experiencing Intimate Partner and Sexual Violence in Adulthood*

| Risk Factors Identified Through All Sources | IPV | SV | Articles/Technical Reports | State Meeting |
|---|---|---|---|---|
| Marital status | | | | |
| Family form | | | | |
| Poverty | | | | Poverty |
| Income/employment | | | | |
| Childhood experiences | | | | |
| Women who were abused (physical or sexual) in both childhood and adolescence more likely "victim" (double victims) | X | X | Violence Against Women: Identifying Risk Factors<br>Parental Caring As A Possible Buffer Against Sexual Re-victimization In Young Adult Survivors Of Child Sexual Abuse | Recognizing first victimization – child abuse<br>Impact of violence on a child's developing brain (i.e. PTSD); prior to any victimization (i.e., primary prevention) |
| Women experiencing child maltreatment more likely "victims" | X | | Wolfe & Jaffe, Prevention of Domestic Violence and Sexual Assault | |
| Power systems | | | | |
| Alcohol abuse | | | | |
| Women using alcohol more likely "victim."* | | X | Violence Against Women: Identifying Risk Factors | |
| Substance use in adolescence* | X | | Wolfe & Jaffe, Prevention of Domestic Violence and Sexual Assault | |
| Sexual behaviors | | | | |
| Women with multiple sexual partners more likely "victim."* | | X | Violence Against Women: Identifying Risk Factors | |
| Traditional Gender Norms | | | | Gender roles/entitlement |
| Peer Influence | X | | Wolfe & Jaffe, Prevention of Domestic Violence and Sexual Assault | |
| The weather | X | | Air Pollution, Weather, and Violent Crimes: Concomitant Time-Series Analysis of Archival Data, Rotton & Frey | |
| Societal | | | | Poor role modeling (music, entertainment) |
| Community | | | | Passive community (lack of involvement, bystander syndrome)<br>Loss of traditional ways for American Indian culture |

| | | | | |
|---|---|---|---|---|
| | | | (prior to colonization, values system, women sacred) | |
| | | | Lower vs. higher income communities; community economic changes | |
| | | | Weak community sanctions (consequences for bullying/enforce policies) | |
| Parenting | | | Lack of parental controls over media (e.g., video games, internet, movies, music) | |
| | | | Role modeling – parents | |

Table 2.19. *Risk Factors for Perpetration of Intimate Partner and Sexual Violence in North Dakota*

| Risk Factors for Perpetrating Intimate Partner and Sexual Violence in Adulthood | IPV | SV | Articles/Technical Reports | State Meeting |
|---|---|---|---|---|
| Marital status | | | | |
| Family form | | | | |
| Poverty | | | | Poverty |
| Income/employment | | | | |
| Childhood experiences | | | | |
| Males who witness family violence as child more likely perpetrator | X | X | Violence Against Women: Identifying Risk Factors<br>Attitudes and Family Violence, Markowitz<br>The Effects of Childhood Exposure to Marital Violence on Adolescent Gender-Role Beliefs and Dating Violence, Lichter & McCloskey | Impact of violence on a child's developing brain (i.e., PTSD); prior to any victimization (i.e. primary prevention) |
| Males who were sexually assaulted as child more likely "perpetrator" | X | X | Violence Against Women: Identifying Risk Factors | Recognizing first victimization – child abuse<br>Impact of violence on a child's developing brain (i.e., PTSD); prior to any victimization (i.e. primary prevention) |
| Power systems | | | | |
| Alcohol use/abuse | | X | Risk Factors for Male Sexual Aggression, Carr & VanDeusen<br>Attitudinal, Experiential, and Situational Predictors of Sexual Assault Perpetration, Abbey, McAuslan, Zawacki, | Alcohol use and abuse |

| | | | | |
|---|---|---|---|---|
| | | | Clinton, & Buck | |
| Sexual behaviors | | | | |
| # of sexual partners | | X | Attitudinal, Experiential, and Situational Predictors of Sexual Assault Perpetration, Abbey, McAuslan, Zawacki, Clinton, & Buck | |
| Pornography | | X | Risk Factors for Male Sexual Aggression, Carr & VanDeusen | |
| Prior sexual relationship between the couple | | X | Attitudinal, Experiential, and Situational Predictors of Sexual Assault Perpetration, Abbey, McAuslan, Zawacki, Clinton, & Buck | |
| Traditional Gender Norms | | | | Gender roles/entitlement |
| Approval of male use of violence | X | X | Violence Against Women: Identifying Risk Factors | |
| | | | Risk Factors for Male Sexual Aggression, Carr & VanDeusen | |
| | | | Men's Attitudes Condoning Marital Aggression, O'Hearn & Margolin | |
| Condoning male sexual violence | | X | Social Norms and the Likelihood of Raping, Boner, Siebler, & Schmelcher | Condoning male sexual violence |
| | | | Rape Prevention with College Males, O'Donohue and Fanetti | |
| | | | Social Norm or Judgmental Anchoring? Eyssel, Bohner, & Siebler | |
| | | | Age as a Modifier of Sexually Aggressive Attitudes in Men, Aromaki, Haebich, & Lindman | |
| | | | Attitudinal, Experiential, and Situational Predictors of Sexual Assault Perpetration, Abbey, McAuslan, Zawacki, Clinton, & Buck | |
| Age | | | | |
| Younger men more likely to report sexual aggression fantasies | | X | Age as a Modifier of Sexually Aggressive Attitudes in Men, Aromaki, Haebich, & Lindman | |
| Antisocial personality | | X | Age as a Modifier of Sexually Aggressive Attitudes in Men, Aromaki, Haebich, & Lindman | |
| Level of isolation of setting | | X | Attitudinal, Experiential, and Situational Predictors of Sexual Assault Perpetration, Abbey, McAuslan, Zawacki, | |

| | | | |
|---|---|---|---|
| | | Clinton, & Buck | |
| Whether disrupted relationship | X | Attitudinal, Experiential, and Situational Predictors of Sexual Assault Perpetration, Abbey, McAuslan, Zawacki, Clinton, & Buck | |
| Societal | | | Poor role modeling (music, entertainment) |
| Parenting | | | Lack of parental controls over media (e.g., video games, internet, movies, music) |
| | | | Role modeling – parents |
| Community disintegrated | | Cunradi, | Loss of traditional ways for American Indian culture (prior to colonization, values system, women sacred) |
| | | | Lower vs. higher income communities; community economic changes |
| Family status | | | Homelessness |
| Individual | | | Low self-esteem (older people trying to socialize with younger people) |
| Bullying | | Middle School Aggression and Subsequent Intimate Partner Physical Violence | Bullying – early form of violence (unhealthy peer interactions) |
| | | Dating Violence & Sexual Harassment Across the Bully-Victim Continuum Among Middle and High School Students | Weak community sanctions (consequences for bullying/enforce policies) |
| Family Relationships | | | Unhealthy family/peer relationship and interactions |
| Peer Relationships | | | Unhealthy family/peer relationship and interactions |

## *Early Childhood Experiences and Their Impact on IPV & SV*

Early childhood experiences are correlated with adult victimization and perpetration of intimate partner and sexual violence, but the relationship is not simple. It is different for victims and perpetrators. Gender differences exist, also. Unfortunately, violence in childhood is common. Tjaden and Thoennes (2000) found in their national phone survey that 50% of the women had been physically assaulted as a child by an adult caretaker and/or another adult.

### *Perpetration*

Males who were abused as children are more likely to be perpetrators of violence in adulthood (Lichter & McCloskey, 2004, Markowitz, 2001). Males who, as children, viewed violence between their parents are more likely to be perpetrators of violence in adulthood (*Violence against Women: Identifying Risk Factors*, 2004).

### *Victimization*

Women who experienced multiple victimizations in early childhood and adolescence are more likely to be victims in adulthood (*Violence against Women: Identifying Risk Factors, 2004*, Wolfe, Jaffe, Wilson, & Kaye, 1997).

### *Rates of Child Abuse in North Dakota*

In ND in 2003, 3,345 children received assessments following a report of child abuse and neglect (see Figure 2.14). North Dakota's rate of children in foster care is 8.2 per 1,000, as compared with 7.2 nationally (Wertheimer, 2006). North Dakota's rate is also high compared to other states in this region (South Dakota, 7.2; Minnesota, 6.4, and Wyoming 7.6).

| | CY 1999 | CY 2000 | CY 2001 | CY 2002 | CY 2003 |
|---|---|---|---|---|---|
| Full Assessments | 4147 | 4055 | 4029 | 4109 | 3903 |
| Administrative Assessments or Referrals | 2082 | 2100 | 2505 | 2938 | 3345 |
| Total Reports | 6229 | 6155 | 6534 | 7047 | 7248 |

*Figure 2.14.* Number of Children Assessed Following a Report of Child Abuse and Neglect

Neglect is the most common category of child abuse and neglect, both in ND and nationally (see Figure 2.15). Although males and females are equally likely to be victims of abuse, males more frequently experience physical abuse; females are more likely to be victims of sexual abuse (see Figure 2.16).

| Type of Abuse | Number | Rate per 100 |
|---|---|---|
| Physical Abuse | 148,877 | 2.3 |
| Neglect | 479,567 | 7.5 |
| Medical Neglect | 17,945 | .3 |
| Sexual Abuse | 78,188 | 1.2 |

| | | |
|---|---|---|
| Psychological Maltreatment | 38,603 | .6 |
| Other | 132,993 | 2.1 |
| | | Child Welfare League of America |

*Figure 2.15.* Rates of Child Abuse Nationally in 2003

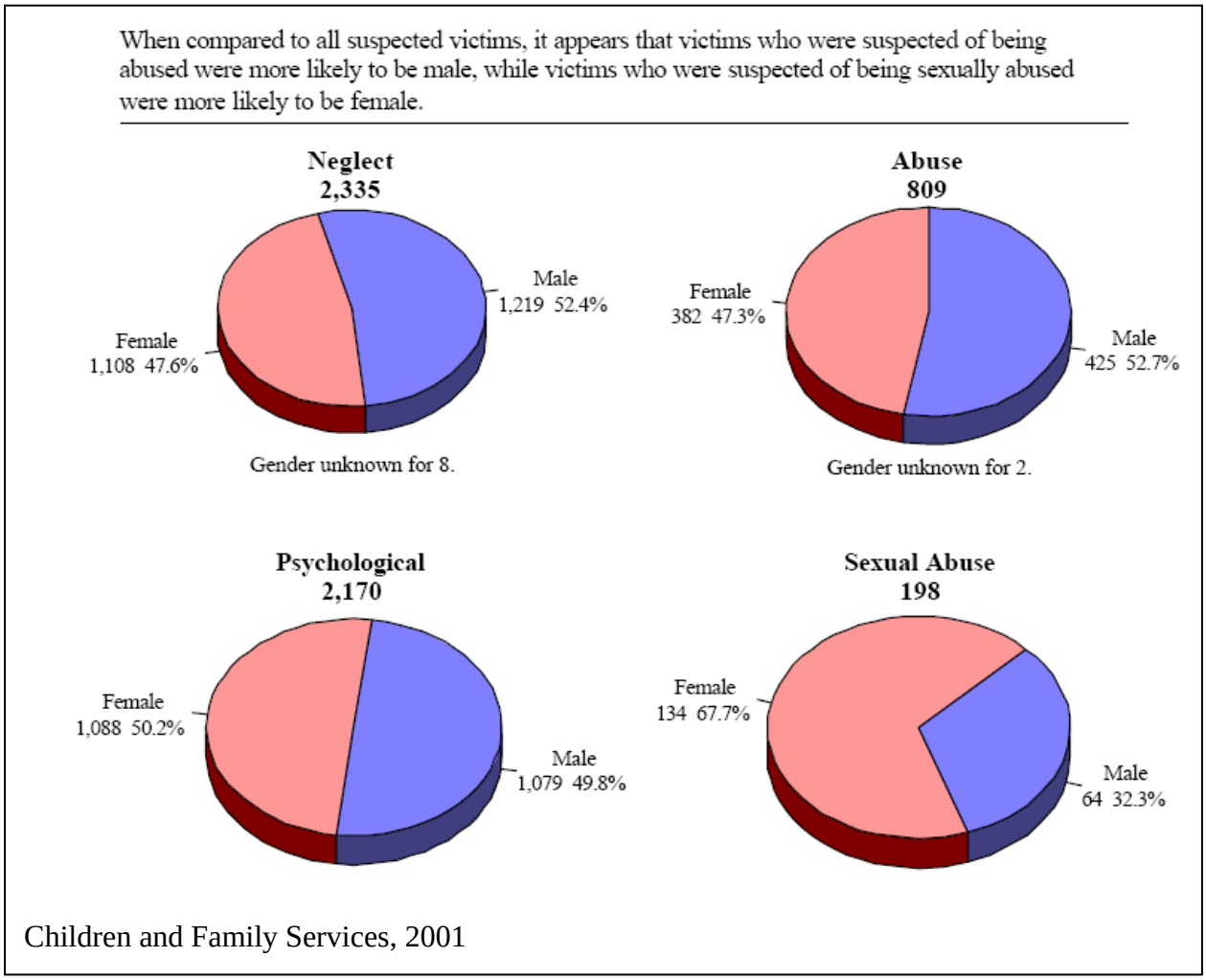



*Figure 2.16.* Reports in North Dakota in 2001 by Gender

### ***Bullying***

Research indicates bullying is related to IPV; for instance, "bully-victims reported significantly more physical dating violence victimization than members of all other groups" (Espelage & Hold, 2007, p. 799). O'Donnell et al (2005) found "perpetration of violence during middle school is related to perpetrating partner violence by young adulthood" (p. 700). National statistics indicate many students are subjected to bullying behavior. In Hoover et al (1992), 75% of adolescents reported being bullied at some point while in school. Bullying has significant effects on those involved. Victims are much more likely to be depressed, suicidal, anxious, absent from school, and drop-out before graduation (Aluede, Adeleke, Omoike, & Afen-

Akpaida, 2008). A study of elementary and middle school students found that 15% of students reported severe distress from bullying and 22% reported academic difficulties due to bullying behaviors by peers (Hoover & Oliver, 1996). Bullies are much more likely to carry a gun or be injured than are students not involved in bullying (Aluede et al., 2008).

### *Magnitude in ND*

The YRBS measures physical acts of violence at school. This survey asks a question about being involved in a physical fight on school property in the last 12 months. ND had a lower percentage of students who said they had been in a physical fight on school property (10.7%), compared to the national average (13.8%). Another question asked students whether they had ever been threatened or injured with a weapon on school property. North Dakota's percentage was again lower (6.6%) than the national average of 7.9%.

### *Demographics*

When examining the demographics of those who either were in a physical fight or had been threatened by a weapon, the majority of students were male; the highest percentage of those who were threatened were in the 9th grade. Incidents of bullying declined with age (YRBS, 2005).

### *A Local Example: Bullying in a Rural Community in Western North Dakota*

Students, parents and teachers in one community completed a prevalence and attitude survey regarding bullying. One hundred and sixty-four students in the 5th, 6th, and 7th grades took the survey. The students indicated that teasing was the most common type of bullying occurring at their school; 66.5% of students indicated they were teased recently (see Figure 2.17).

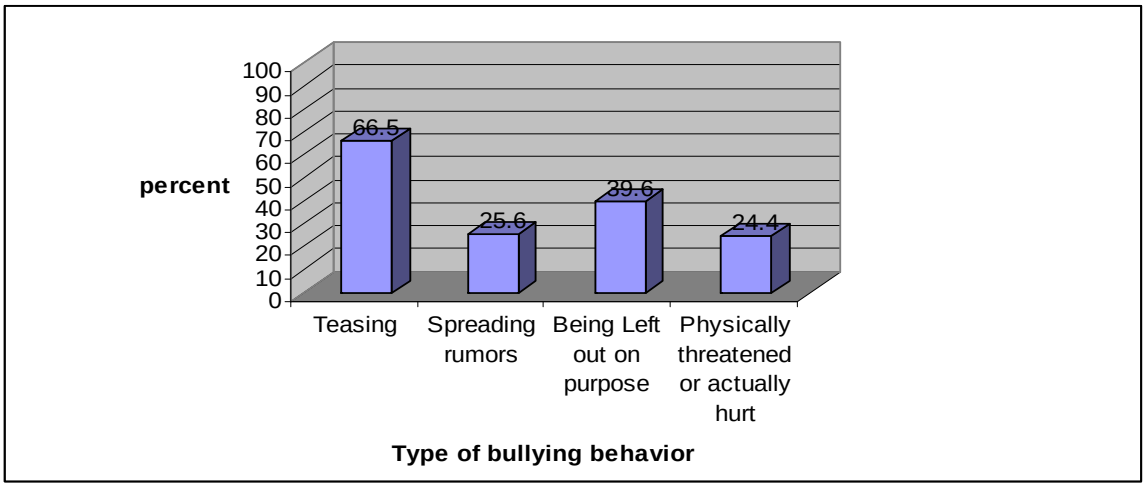



*Figure 2.17*. Percent of Students Who Were Bullied, By Type

Across the different types of bullying (teasing, spreading rumors, being left out, and physically threatened or actually hurt), students who were being bullied reported these bullying behaviors happening at least once a week (see Figure 2.18).

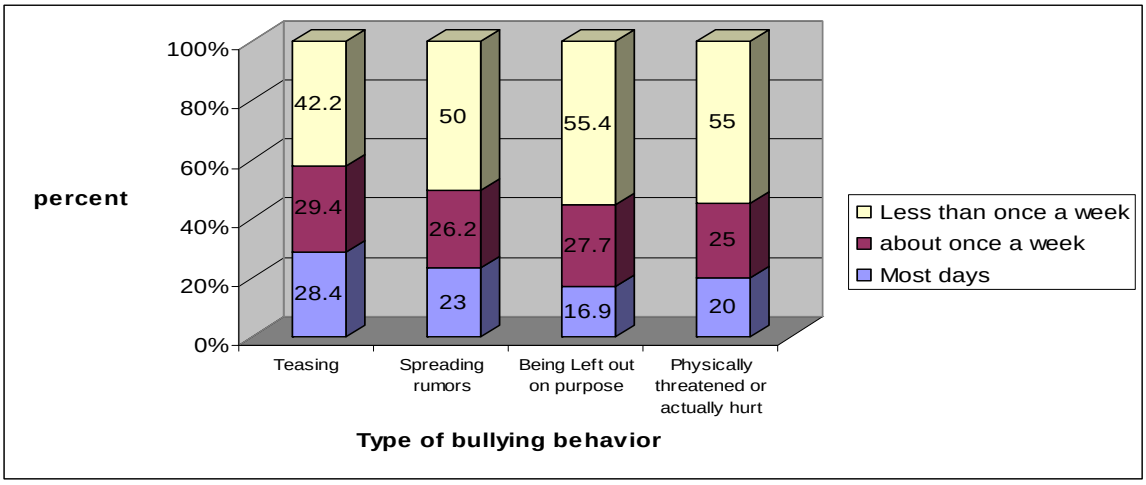



*Figure 2.18.* Magnitude of Bullying Behavior

According to the prevalence survey, students who were female were more likely to be left out on purpose and students who were male were more likely to be physically threatened or actually hurt by another student. The rate of bullying was similar for students in each grade surveyed (5, 6, and 7).

The attitudinal survey (Salmivalli, 2005) revealed a significant relationship among gender and the "no bullying scale". Females scored higher on the "no bullying scale" and therefore were less supportive of bullying. The student's grade level in school did not show a significant relationship with the "no bullying scale".

Parents also believed teasing was the most common form of bullying (see Figure 2.19).

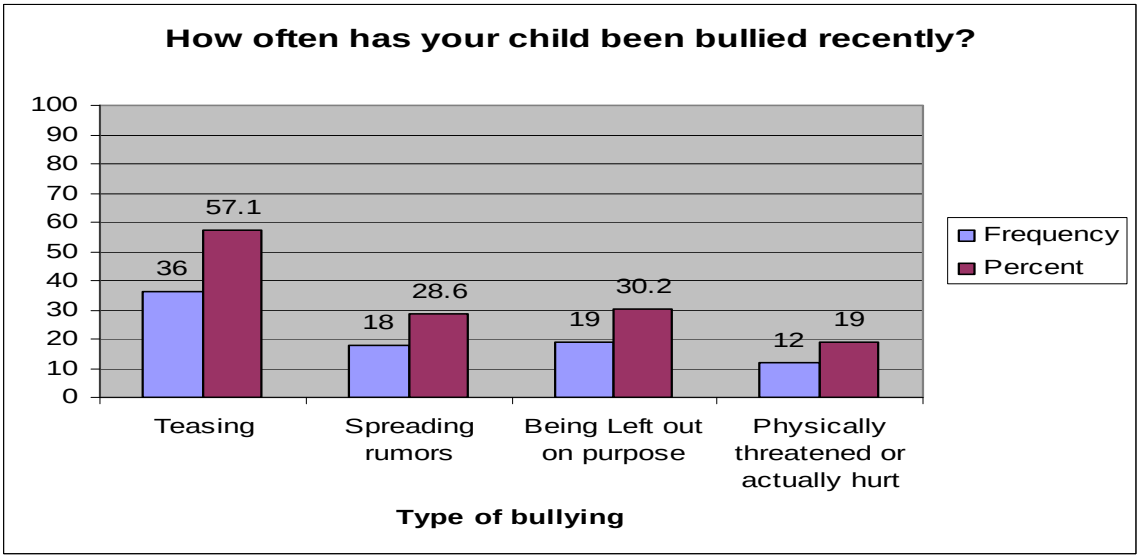



*Figure 2.19.* Type of Bullying by Percent and Frequency

Those parents who felt their child was bullied recently reported this behavior happening quite often (see Figure 2.20).

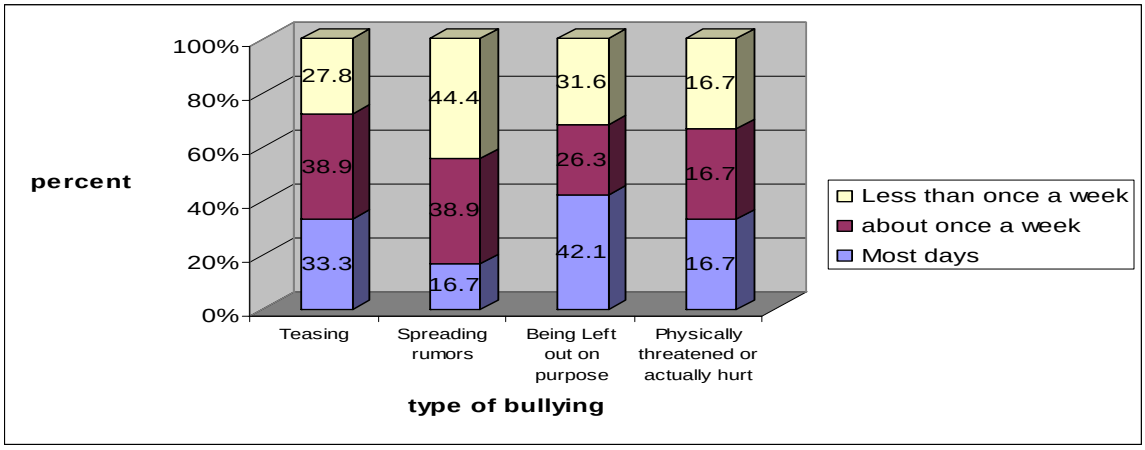



*Figure 2.20.* Magnitude of Bullying Behavior Reported by Parents

Parents also completed attitudinal questions (Rigby, 1991). Each question was scored on a Likert scale of 1 (strongly disagree) to 5 (Strongly agree). According to previous pro-victim research, half of the questions needed to be recoded (Rigby, 1991). After the questions were re-coded, the means were ranked according to agreeability to the question. Parents agreed most strongly with "It's sad to see kids get upset when they are teased" (Mean=4.98) and "I am not sickened by children who are soft" (Mean=4.98). Parents agreed the least with "Kids who hurt others weaker than themselves should be told off" (Mean=2.70) (see Table 2.20).

Table 2.20. *Attitudes Towards Bullying – Ranked by Parents*

| Attitudes, Parents | | |
|---|---|---|
| | N | Mean |
| It's sad to see kids get upset when they are teased. | 63 | .126 |
| I am not sickened by children who are soft. | 63 | .479 |
| I like it when someone sticks up for kids who are being bullied. | 62 | .641 |
| It makes me angry when a kid is picked on without reason. | 62 | .690 |
| Kids should complain when they are bullied. | 63 | .592 |
| Nobody likes a wimp (not reworded, but recoded). | 62 | .619 |
| You should not pick on someone who is weaker than you. | 62 | .998 |
| Kids who get picked on a lot do not usually deserve it. | 62 | .664 |
| A bully is really a coward. | 63 | 3.952 |
| Kids who hurt others weaker than themselves should be told off. | 61 | 1.667 |

Fifteen school personnel completed the bullying survey. All school personnel indicated they had seen bullying in their school community. According to school personnel, teasing (Mean=3.4) and name calling (Mean=3.33) were the most common types by bullying (see Table 2.21).

Table 2.21. *Frequency of Bullying – Ranked Means by Type of Bullying*

| Frequency of bullying, ranked means but type of bullying | | |
|---|---|---|
| | N | Mean |
| Unwelcome sexual comments, gestures or touching | 15 | 1.87 |
| Threatening or intimidation | 15 | 2.13 |
| Hitting, pushing or kicking | 15 | 2.60 |
| Being excluded or left out | 15 | 3.27 |
| Name calling | 15 | 3.33 |
| Teasing | 15 | 3.40 |

School personnel were asked to indicate the degree to which bully prevention initiatives were present in their school. Each school personnel ranked each initiative from 1 (not in place) to 5 (currently in place). The initiatives with the highest means were: individual counseling for students who have been bullied (Mean=4.07), individual counseling for student who have bullied others (Mean=4.00), and school policies and rules related to bullying (Mean=3.87). Those initiatives that seemed to be the least in place were involvement by students in bullying prevention committee (Mean=1.43), bullying prevention committee (Mean=1.57), and student lead activities focused on bullying (Mean=1.64). A 10 question attitudinal survey, the same survey administered to parents, was given to school personnel. School personnel ranked each questions from 1 (strongly disagree) to 5 (Strongly agree). Questions were re-coded in order for answers to reflect desirable anti-bullying attitudes. About half of the questions had a higher standard deviation (above 1), which indicates that teachers' attitudes varied widely (see Table 2.22). Over half of the questions had a mean over 4; overall, teachers were opposed to bullying.

Table 2.22. *Attitudes Towards Bullying – Ranked by Teachers*

| Attitudes, Parents | | |
|---|---|---|
| | N | Mean |
| I am not sickened by children who are soft. | 15 | 5.00 |
| It's sad to see kids get upset when they are teased. | 15 | 4.80 |
| I like when someone sticks up for kids who are being bullied. | 15 | 4.73 |
| Kids should complain when they are bullied. | 15 | 4.73 |
| Kids who get picked on a lot do not usually deserve it. | 15 | 4.53 |
| You should not pick on someone who is weaker than you. | 15 | 4.27 |
| Nobody likes a wimp (not reworded but recoded). | 15 | 4.27 |
| A bully is really a coward. | 15 | 3.80 |
| It makes me angry when a kid is picked on without reason. | 15 | 3.80 |
| Kids who hurt others weaker than themselves should be told off. | 14 | 1.57 |

### ***Communities and Violence***

Rates of violence vary by characteristics of communities. Community factors correlated with higher rates of violence include 1) community sanctions for violence, or conversely, weak community sanctions against IPV, 2) disintegrated or changing community, as measured by high rates of gang activity, and 3) communities with a lack of resources, as measured by poverty rates (CDC/NCIPC IPV Fact Sheet, *A Call to Men*, Sexual Violence). Much of the research regarding

community factors that correlate with higher rates of IPV and SV was based in urban centers. The next step is to determine how these factors fit in ND.

***Violence***

ND reports rates of violent crimes, and reports those rates to the FBI (Stenjhem, 2000). The Uniform Crime Index is based on reports of forcible rape, robbery, aggravated assault, burglary, larceny/theft, and motor vehicle theft. "The index crime rate per 100,000 population for 2000 was 2203.4" (p. v). The violent crime rate, murder/non-negligent manslaughter, forcible rape, robbery, and aggravated assault, for 2000 was 87.5. The counties with the highest rates of violent crimes were the three most populated counties, Cass, Burleigh and Grand Forks, with Grand Forks by far the highest (3,906). The counties with the next highest rates were Morton, Richland, Stutsman, Walsh, and Ward Counties. North Dakota's violent crime index is by far the lowest in the nation (US Bureau of Justice Statistics, 2004). Its rate for rape was 25.1 in 2004, compared with 32.2 nationally. It ranks 11$^{th}$ from the bottom in rate of rapes. Alaska is by far the highest, at a rate of 85.1 per 100,000. Rates are varied in neighboring states; South Dakota's rate is 43.8, Minnesota's 41.6, Montana's 29.5, and Wyoming's 22.1.

One important caveat regarding this data is the lack of consistent information from "Indian reservations, military installations, and national parks" (Maltz, 1999, p. 5). Additionally, looking at rates by county may hide pockets of crime in smaller geographic areas or areas that transcend county lines.

***Poverty***

Counties with the highest rates of poverty in ND are Rollette, Benson, Sheridan, Grant, Sioux, and Emmons (see Figure 2.21). Children in rural ND areas are more likely to be in poverty than children in urban areas in ND and nationally (Dalaker, 2004). 16.7% of children in rural areas in ND live in poverty, as opposed to 10.2% of children in the same situation in Wisconsin. The only other two states in this region with higher rates of rural children in poverty are Missouri and South Dakota.

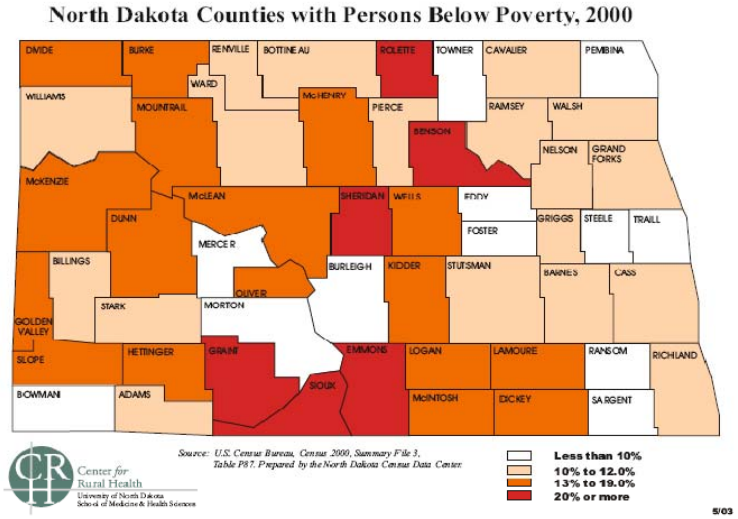



*Figure 2.21.*Persons in Poverty in North Dakota

### *Racism*

Racism has been identified as a community factor that correlates with higher rates of violence. Kawamoto (2001) suggested that historical events such as boarding schools and the Dawes Act have increased rates of domestic violence, as have others (Abril, 2007; Bent-Goodley, 2007; Evans-Campbell, 2006). Thurman, Bubar, Plested, Edwards, LeMaster, Bystrom, Hardy, Tahe, Burnside, and Oetting (2003) found, through data collection at 15 reservations, that women feared men of authority in their community, who were also offenders.

### *Alcohol*

Alcohol abuse has links to intimate partner violence and sexual violence. Alcohol abuse has been identified as a strong correlate of college rape **(**Abbey, 1991; Abbey *et al.*, 1996; Frintner & Rubinson, 1993; Koss & Gaines, 1993; Muehlenhard & Linton, 1987; Norris & Cubbins, 1992; Prentky & Knight, 1991; Presley *et al.*, 1998**).** Men who sexually and physically assaulted women were significantly more likely to abuse drugs and alcohol (U.S. Department of Justice, *Violence against Women: Identifying Risk Factors*). The relationship between alcohol and rape is multifaceted, and alcohol may be both a precipitant of and an excuse for sexually aggressive behavior by men (Abbey *et al.*, 2001; Berkowitz, 1992; Larimer *et al.*, 1999; Richardson & Hammock, 1991).

IPV rates for "high moderate" drinkers were twice as high and the rates for binge drinkers were three times as high as nondrinkers (Kaufman Kantor, & Straus, 1990). The National Violence Survey and National Violence Against Women Survey estimate that binge drinkers are three to five more likely to be violent against a female partner than those who do not drink. However, many other studies have maintained that the evidence to date does not provide adequate empirical support that alcohol and drug use are causally related to IPV. The best to say is that substance abuse is highly correlated with IPV among batterers (Buzawa & Buzawa, 2003).

### *Magnitude*

According to the BRFSS, ND has a higher percentage of binge drinkers (21%) than the national median (15.3%) (see Table 2.23).

Table 2.23. *BRFSS Questions Related To Alcohol Consumption*

| Questions | National Median | North Dakota |
|---|---|---|
| Heavy drinkers (adult men having more than two drinks per day and adult women having more than one drink per day) | 4.90% | 4.40% |
| Binge drinkers (males having five or more drinks on one occasion, females having four or more drinks on one occasion) | 15.30% | 21.00% |

The YRBS, asks students in high school about alcohol consumption. ND has a higher percentage than the nation in both categories (one drink; binge drinkers) (see Table 2.24).

Table 2.24. *YRBS Questions Related to Alcohol Consumption*

| Questions | National Median | North Dakota |
|---|---|---|
| Percentage of students who had at least one drink of alcohol on one or more of the past 30 days | 43.40% | 49% |
| Percentage of students who had five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days | 25.5% | 33.80% |

The Core Alcohol and Drug Survey (2003-2005), which was administered to 10 ND universities, reported 24% of the students drinking once a week and 18.3% drinking three times a week (see Figure 2.22). According to the ND Uniform Crime Reporting Program, 41% of domestic violence arrestees were reported to be using alcohol.

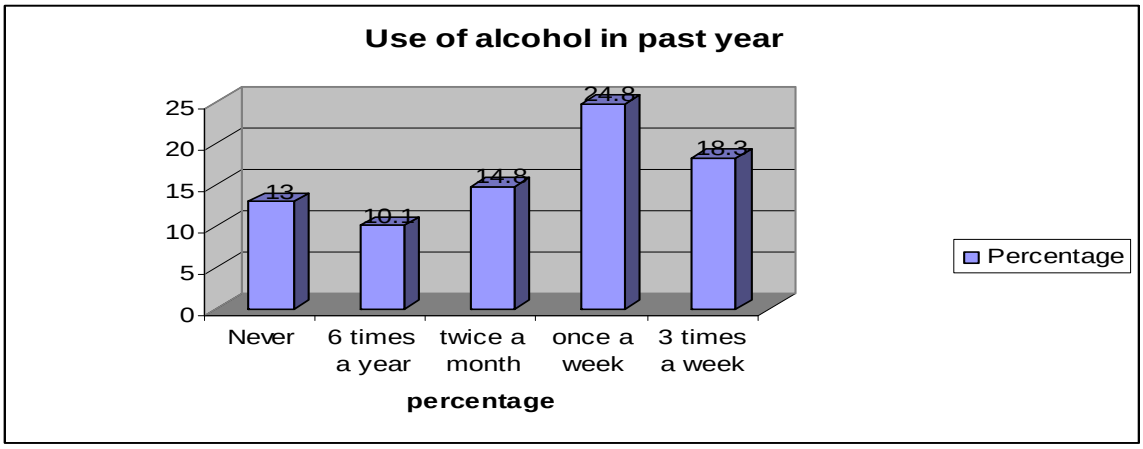



*Figure 2.22*. Use of Alcohol in Past Year

***Demographics***

According to the BRFSS, twice as many men (28%) binge drink than females (14%), and people between ages 18 and 34 are the highest percent of binge drinkers. Also, the lowest and highest income groups have the highest percent of people who binge drink. The YRBS indicated that those in ND who binge drink (five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days) are slightly more likely to be male (36.2%) than female (31.2%). Also, eleventh (41.7%) and twelfth (45.7%) graders have a higher percent of students who binge drink than students in grades 10 (29.5%) and 9 (19.3%). Of those who reported binge drinking, 33% were white and 41% were all other races.

## *Gender Role Attitudes*

***BRFSS Data***

Data related to attitudes about sexual violence are collected through the North Dakota BRFSS. These results highlight some common misconceptions about sexual violence and how

community perception of these crimes may impact planning for sexual violence prevention (see Table 2.25).

Table 2.25. *2007 BRFSS Data Regarding Sexual Violence*

| Question | Agree % | Disagree % | Don't Know % |
|---|---|---|---|
| Media images that portray women as sexy contribute to sexual violence. Would you say that you agree or disagree? | 54.6 | 40.3 | 5.1 |
| Please tell me if you agree with the following statement. Women who dress and act in a sexy way provoke rape if their appearance and behavior. Sexual harassment can include inappropriate or unwanted sexual advances or comments by another person, co-worker or supervisor. | 36.3 | 59.2 | 4.5 |
| Please tell me if you agree with the following statement. Sexual harassment can include inappropriate or unwanted sexual advances or comments by another person, co-worker or supervisor. | 92.5 | 5.0 | 2.5 |
| Do you agree or disagree with the following situation? It might be acceptable for a male to have sexual intercourse with a female against her will or without her consent if he spends a lot of money on her. | 1.6 | 97.4 | 1.0 |
| Do you agree or disagree with the following situation? It might be acceptable for a male to have sexual intercourse with a female against her will or without her consent if she got him sexually excited. | 3.9 | 93.7 | 2.3 |
| Do you agree or disagree with the following situation? It might be acceptable for a male to have sexual intercourse with a female against her will or without her consent if they had had sexual intercourse before. | 5.1 | 92.0 | 2.9 |
| Do you agree or disagree with the following situation? It might be acceptable for a male to have sexual intercourse with a female against her will or without her consent if they were married. | 10.6 | 86.1 | 3.3 |
| It is never acceptable for a male to have sexual intercourse with a female against her will or without her consent. Would you say you agree or disagree? | 94.2 | 5.1 | 0.7 |
| If a woman claims she is raped, the amount of resistance she put up should be a major factor in determining whether a rape has occurred. Would you say you agree or disagree? | 29.8 | 64.0 | 6.2 |
| If a woman is raped when she is drunk, she is at least somewhat responsible for letting things get out of control. Would you say you agree or disagree? | 26.2 | 69.2 | 4.6 |

| | | | |
|---|---|---|---|
| I would have sex with someone against their will or without their consent if I knew I would not get caught. Would you say you agree or disagree? | 1.3 | 97.9 | 0.8 |

***Cass County Survey***

People who hold more traditional gender norms are more likely to be perpetrators. Studies involving young adult males reveal that males who score high on rape-myth acceptance measures and believe that relationships are adversarial are also more likely to report having committed rape (Loh, Gidycz, Lobo, & Luthra, 2005). To learn more about attitudes in North Dakota, The Rape and Abuse Crisis Center (RACC) of Fargo-Moorhead conducted a random phone survey of Cass County residents. They created a 30 item survey using information from other surveys, including items provided by the CDC to the DELTA project and the Rape Myth Acceptance Scale. Items were rated on a scale of 1 Strongly Disagree to 5 Strongly Agree. Examples of items included:

- When women talk and act sexy, they are inviting rape.
- If the husband insists, the wife should quit a job.

The UND Social Science Research Center identified the sample through random digit dialing of households in Cass County. The average age of the 383 respondents was 43.06. Sixty-two percent were married (see Figure 2.23); 51.2% were female. More had advanced degrees beyond the high school diploma (see Figure 2.24). The most common income was $45-$70,000 (see Figure 2.25)

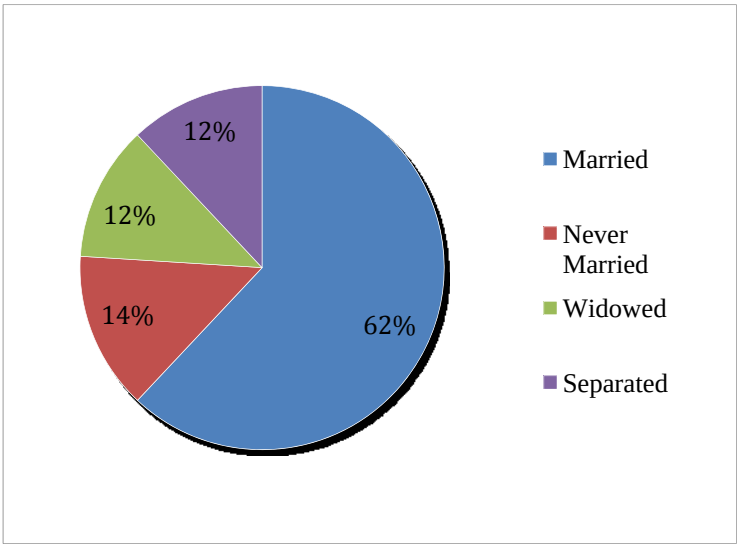



*Figure 2.23.* Marital Status

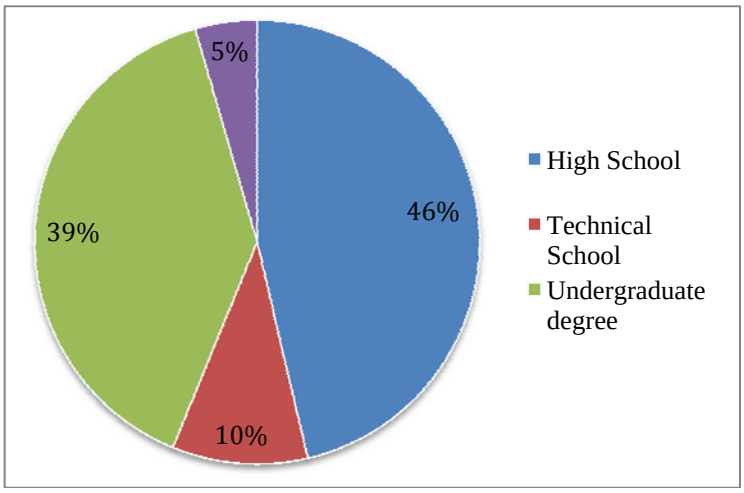



*Figure 2.24.* Level of Education

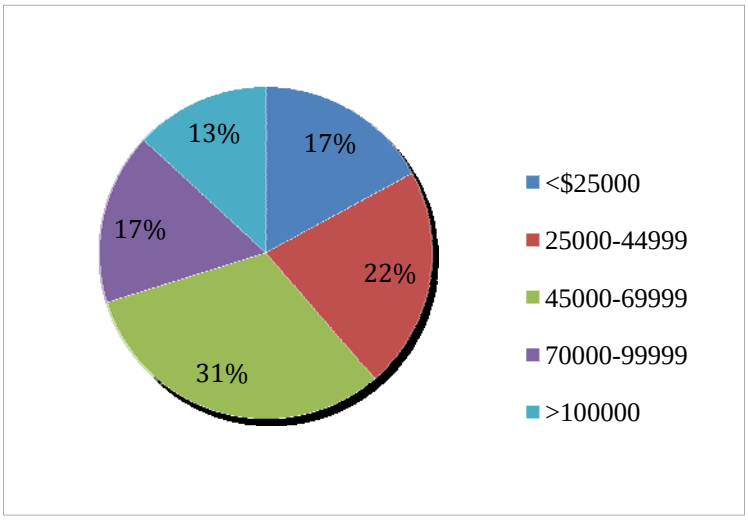



*Figure 2.25*. Income

Overall, attitudes were rated as less traditional. Males in the survey held more traditional gender norms than females. The lowest income group reported the most traditional gender norms. Persons with a high school degree had more traditional gender norms. Norms did not differ by age. Responses to some items had variability:

Table 2.26. *Attitudes Towards Traditional Gender Norms*

| | Strongly Disagree | Mildly Disagree | Neutral | Mildly Agree | Strongly Agree |
|---|---|---|---|---|---|
| When women talk and act sexy, they are inviting rape. | 74% | 8% | | | |
| When a woman allows petting to a certain point, she is agreeing to have sex. | 72% | 12% | | | |
| When men rape, it is because of | 63% | 10% | | | |

| | | | | | |
|---|---|---|---|---|---|
| their strong desire for sex. | | | | | |
| Men and women should equally take the initiative when it comes to sex. | | | | 14% | 70% |
| Many so-called rape victims are actually women who had sex and "changed their minds" afterward. | 50% | 17% | | | |
| Men don't usually intend to force sex on a woman, but sometimes they get too sexually carried away. | 35% | 15% | 24% | 11% | 15% |
| What a husband does in his spare time is his business. | 68% | 13% | | | |
| The wife should take her husband's religion as her own. | 66% | 14% | | | |
| If the husband insists, the wife should quit a job. | 66% | 13% | | | |
| If the husband wants children, then the wife should agree. | 59% | 11% | | | |
| The wife should be free to go out nights by herself. | 18% | 7% | 16% | 14% | 45% |
| If the wife wants children, the husband should agree. | 44% | 13% | 28% | 3% | 12% |

Idiosyncrasies of the study affect its reliability and validity. A high number of males refused to participate when contacted. The survey was a compilation of items from different sources. The survey was conducted during June, which may impact on participation.

This information is being used by Cass County to target their prevention program, and it may offer information for other geographic areas, especially for the urban areas. Attitudes may vary by region of the state and level of rurality.

***Traill County Survey***

The Rape and Abuse Crisis Center of Fargo-Moorhead's DELTA project in Traill County mailed a survey to all postal addresses in the county in 2005 to assess values, beliefs and attitudes that may lead to domestic violence. Three hundred and fifty-two responded. A majority of the respondents were female. Respondents were more likely to be 46 years of age or older.

The means of the items regarding attitudes ranged from 4.66, "Women should be given equal opportunity with men for career advancements," to 3.38, "Boys should **not** prefer to play with trucks rather than dolls" (see Table 2.26).

Table 2.27. *Attitudes Towards Intimate Partner Violence*

| Items Regarding Attitudes Towards Intimate Partner Violence | Mean |
|---|---|
| Women should be given equal opportunity with men for career advancements. | 4.66 |
| Under modern economic conditions with women being active outside the home, men should share in household tasks such as washing dishes and doing laundry. | 4.61 |
| Sons and daughters should be given equal encouragement to go to college. | 4.58 |
| It is perplexing why someone would physically abuse their partner if they continually withheld sex from them. | 4.47 |
| The victim never deserves the abuse. | 4.39 |
| Men and women should equally make the final decision involving money. | 4.37 |
| The intellectual leadership of a community should **not** be largely in the hands of men. | 4.36 |
| In general, the father and mother should have equal authority in bringing up the children. | 4.34 |
| It is **not** ridiculous for a woman to run a company and for a man to be a stay-at-home dad. | 4.32 |
| Men and women should equally take the initiative when it comes to sex. | 4.18 |
| Jobs like firefighter and electrician should **not** be reserved just for men. | 4.06 |
| Victims of domestic violence who are unfaithful are **not** to blame for provoking the abuse. | 4.00 |
| A woman should be as free as a man to propose marriage. | 3.82 |
| Men and women should be given equal preference in being hired or promoted. | 3.79 |
| Women should worry more about their rights and less about becoming good wives and mothers | 3.67 |
| Women earning as much as their dates should bear equally the expense when they go out together. | 3.66 |
| Men don't have to do whatever it takes to be admired and respected. | 3.57 |
| When the going gets tough, men don't have to get tough. | 3.49 |
| Boys should **not** prefer to play with trucks rather than dolls. | 3.38 |

***Golden Valley, Hettinger, and Dunn Counties Surveys***

The Domestic Violence and Rape Crisis Center in Dickinson, North Dakota, surveyed households in Golden Valley, Hettinger, and Dunn Counties. Surveys were mailed to all postal addresses; of the 440 who returned surveys, 80% were female. Most were 45 or older (see Table 2.27). More surveys represent Hettinger County (45%).

Table 2.28. *Age of Survey Responders*

| Age | N | % |
|---|---|---|
| Less than 29 | 25 | 6 |
| 30-45 | 79 | 18 |
| 46-60 | 169 | 38 |
| 60+ | 167 | 38 |

The highest rated item addressed equal career opportunities for women (see Table 2.28).

Table 2.29. *Highest Rated Items*

| Question | Mean |
|---|---|
| Women should be given equal opportunity with men for career advancements | 4.49 |
| Children who witness abuse are negatively impacted. | 4.09 |
| Anyone who beats their partner should be arrested. | 4.18 |
| Victims of domestic violence should immediately seek assistance from others. | 3.94 |
| There is a strong relationship between alcohol/drug use and domestic violence. | 3.92 |
| Domestic violence is a serious problem in our community. | 3.44 |
| The rate of domestic violence in our society is a reflection of our societal values. | 3.48 |
| Domestic Violence is unacceptable. | 3.81 |

Items were grouped into three scales (see Table 2.29). Scale 1, Acceptability of Domestic Violence," contained nine items, such as "I believe it is possible to prevent domestic violence" and "There is no justification for anyone to hit their partner." Scale 2: Traditional Gender Role Attitudes contained four items: Sons in a family should be given more encouragement to go to college than daughters; In general, the father should have greater authority than the mother in bringing up the children; Jobs like firefighter and electrician should be reserved for men; Men should make the final decision involving money. Scale 3: Attitudes towards Rates of Domestic Violence and People, who are Lower Income, Minority, and Immigrant, contained three items. Counties responded similarly. People responded similarly by age on Scale 1. The older a person was, the higher their score on Scales 2, Gender Role Attitudes, meaning that they were more likely to hold traditional gender role attitudes. Scale three, Domestic Violence and Populations, was inconsistent. People who were in the 45-59 age group were less likely to believe that domestic violence is more prevalent in people who are poor, minority, and immigrant than the other three age groups. They were most likely to believe that domestic violence occurs more frequently among people who are poor, minority, and immigrant were the two younger age groups. Males were more likely to hold traditional gender role attitudes than females. Men's and women's attitudes did not vary on Scale 1 and 3.

Table 2.30. *Attitudes Towards Domestic Violence*

| | N | Mean |
|---|---|---|
| Domestic Violence Unacceptable | 8 | 34.2685 |
| Gender Role Attitude | 7 | 7.0520 |
| Attitudes Towards Domestic Violence and Special Populations | 2 | 8.3653 |

### ***Factors Combined***

Considering the interaction between factors provides a more accurate picture of predictors of violence, both perpetration and victimization, than thinking of each factor as an independent actor. For instance, men who experienced abuse as a child are more likely to be perpetrators in adulthood when they also hold more traditional gender role attitudes (O'Hearn & Gayla, Margolin, 2000). Men who hold traditional gender role attitudes and who are in the company of other men who hold similar norms are more likely to perpetrate (Bohner, Siebler, & Schmelcher**,** 2006). Women who were abused in childhood and then re-experienced

victimization in adolescence are more likely to be victims in adulthood than those women who experienced only one episode of victimization.

## Protective Factors for Intimate Partner and Sexual Violence

Little is known about what factors can lessen the likelihood of IPV or SV victimization or perpetration, although the Search Institute has proposed assets that might apply **(http://www.search-institute.org/assets/forty.html).**

## Conclusions and Recommendations

The purpose of this needs and resource assessment for ND is to 1) examine the current needs and resources, 2) determine the magnitude of intimate partner and sexual violence, and 3) learn more about the level of awareness regarding intimate partner and sexual violence. The information is used to create primary prevention goals and outcomes for intimate partner and sexual violence.

Understanding the definitions being used in different publications and data reports is critical to understanding magnitude and impact of IP and SV. The differing definitions frequently reflect different values, which impact on prevention programming. This report is guided by public health principles, especially those related to primary prevention; the ecological perspective (addressing various levels such as individual, family, community and societal); and Empowerment Evaluation. This project, funded through the U.S. Centers for Disease Control, uses its definition to guide the work.

### *What We Learned*

ND is a rural, sparsely populated state, with 9.5 persons per square mile. It has three urban areas, surrounded by rural farming and ranching communities. The energy industry and two air force bases play a significant role in the economy of the state as well. The average age of residents in North Dakota (36.2) is higher than the national average (35.3). Rural counties particularly have an older population, with the exception of the tribal entities. Intimate partner and sexual violence are reported through the domestic violence and sexual assault programs and law enforcement. Victims reported through these systems are more likely to be young adult females. Perpetrators are primarily males.

Intervention services for intimate partner and sexual violence are available through the network of 21 organizations participating in NDCAWS/CASAND. Many of those organizations are participating in this project to prevent intimate partner and sexual violence. A host of other organizations are potential partners, such as Future Career and Community Leaders of America, the North Dakota University System, and the Department of Public Instruction. Some other prevention programs which have preceded intimate partner and sexual violence prevention programming in ND, such as substance abuse, will provide guidance about effective prevention strategies that have worked in their arena.

Risk factors for intimate partner and sexual violence include traditional gender role norms, community factors, bullying, substance use, and child abuse and neglect. Because few protective factors preventing perpetration or victimization have been identified nationally, they were not pursued in this needs and resource assessment.

### *What We Still Need to Know*

Areas where we still have gaps in knowledge include: 1) data, 2) characteristics of perpetrators, 3) risk factors that are significant in ND, 4) protective factors and rates of risk, and 5) regional similarities and differences.

### *Thinking about Data*

Results from studies regarding rates, demographics, and risk factors must be considered with a grain of salt. Factors that influence the results include: 1) confusing and/or inaccurate data because of differences in definition and analysis, 2) unique characteristics of the sample, which result in unique results that are not easy to generalize, 3) underreporting of sensitive information, 4) measurement can influence the results, and 5) political and social factors may influence what data is made available and how it is presented.

Data may appear confusing. For instance, Fargo is listed as the 12th safest city in the nation in **2005 (**http://www.citizendefensetraining.com/crime_report.htm**).** On the other hand, the rate of rape in Fargo is higher than the national average, based on the same data set but a different way of examining the data (Crime Statistics, http://www.cityrating.com/citycrime.asp?city=Fargo&state=ND**).** Because other violent crimes are so much lower, the higher rates regarding rape don't stand out in the first method of thinking about violence. Knowledge about how the data is collected and analyzed helps one better understand the discrepancies between results across reports.

Some data may not be accurate. One reason for inaccuracies is underreporting by people who experience intimate partner or sexual violence. Uncertainty about whether an event fits the categories of intimate partner or sexual violence, stigma, fear, a sense of hopelessness, and lack of access prevent reporting. Systemic factors may influence underreporting, such as defining an act as other than rape takes it out of the "count" even if reported and prosecuted. Given underreporting, one must assume that existing records regarding rates of intimate partner and sexual violence may not be able to be generalized to the larger population of all women who are victims of violence. Legislation about definitions and social factors influence whether formal systems respond to and report an act as intimate partner and/or sexual violence. In some systems, the provider decides whether to consider an act as intimate partner or sexual violence, even though both may have occurred within the same couple relationship. Over reporting can occur when a system does not record information by a unique identifying number. A person might be served in more than one service delivery system and therefore one act may be counted more than one time. Data may be influenced by political and societal influences. Victims, families, organizations and communities might have reasons to inflate or deflate data.

### *Characteristics of Perpetrators*

Little is known nationally and statewide regarding perpetrators. The information available in ND is primarily reported by victims. This complicates the development of prevention strategies for intimate partner and sexual violence perpetration.

### *Which Risk Factors Are Particularly Important in ND*

Learning more about the risk factors that are most important in ND will further enhance our ability to tailor prevention programming. Some data is available statewide. For instance, traditional gender role norms are a risk factor for perpetration. Changing those might be more of a challenge in ND. A national study rated ND as the state least open to change (Rentfrow, Gosling, & Potter, 2008). Because risk factors may vary from one area to another, information might need to be based on local and regional data to support prevention through local IP and SV organizations and community teams. This might also include piloting prevention strategies that worked in other states, in order to learn how to successfully adapt them for ND.

### *Protective Factors*

Identifying protective factors for prevention of violence will require national and international efforts. One local domestic violence and sexual assault program in ND is using a Grounded Theory approach in their community to identify protective factors to prevent males from becoming perpetrators. With many different people at different places working on this, eventually more information will be available to support which protective factors on which to focus.

### *Regional Similarities and Differences*

Population data is available to identify similarities and differences in different regions of the state, for instance, the two communities with air force bases, the tribal entities, farm regions, the ranching region of the state, and the “oil patch” areas in North Dakota. More difficult to address are similarities and differences regarding attitudes and readiness to adopt violence prevention strategies.

### *Recommendations*

- Increase participation in prevention planning and implementation of prevention strategies by underrepresented groups, such as people living on tribal lands, persons with disabilities, persons who are gay/lesbian/bisexual/transgendered, and men.
- Create a centralized method for collecting, analyzing, and disseminating data.
- Identify evidence based or supported prevention strategies and support their adoption statewide.
- Create a sustainability plan to implement the strategies identified.
- Develop more individualized assessments of local readiness to change, regarding prevention of violence, and more targeted strategies based on those assessments.

# CHAPTER THREE: GOALS, OUTCOMES AND STRATEGIES/ACTIVITIES

Based on the Needs and Resources Assessment, the experience and knowledge of participants, as well as the best available research in the field, the State Prevention Team (SPT) identified three areas of focus for the State Intimate Partner and Sexual Violence Prevention Plan: partnerships and capacity of the state to support the implementation and sustainability of the project; the availability and accuracy of data needed to guide planning, implementation and evaluation; and creating a framework for supporting the increase in number and effectiveness of prevention strategies implemented.

A 2006 national evaluation of community coalitions highlighted key components to successful coalitions. The study of programs, related to prevent and reduce substance abuse, found that the most successful coalitions are characterized by the following:

- Greater perceived ability to sustain coalition leadership
- Greater likelihood of using primarily evidence-based strategies
- More proficient in assessing the knowledge and skills among their coalition and community members to do coalition work
- Research and data driven

*http://www.coalitioninstitute.org/*

In combining this knowledge, with the data from the Needs and Resources Assessment, provided the framework for the SPT to focus and prioritize the goals for this plan. These areas have been further developed to include outcomes and strategies/activities. As well, corresponding logic models have been included to provide a visual structure for each goal. The SPT identified the following goals:

| |
|---|
| Increase the effectiveness and sustainability of the North Dakota Intimate Partner and Sexual Violence State Prevention Team. |
| Increase the availability of data in ND regarding intimate partner and sexual violence for planning and evaluation. |
| Increase the use of evidence supported and evidence based strategies to prevention intimate partner and sexual violence in ND. |
| Increase norms and behaviors that prevent intimate partner and sexual violence in ND. |

Goal 1:
Increase the effectiveness and sustainability of the North Dakota Intimate Partner and Sexual Violence State Prevention Team (SPT).

Outcome 1.1. The leadership of the SPT will be strengthened.

Activity 1. Ongoing assessment of characteristics of membership needed to accomplish IPV and SV prevention.

Activity 2. Recruit and retain members, including ongoing assessment of member needs and development and implementation of strategies for meeting those needs.

Activity 3. Formalize membership on SPT through memorandums of understanding or other statements of commitment.

Activity 4. Create structure for the team, including leadership and committee structure (Partnership, Data and Innovations Committees).

Activity 5. Develop, implement and evaluate methods for effective meetings.

Activity 6. Create linkages with state, regional and local entities.

Outcome 1.2. Resources to sustain the prevention of intimate partner and sexual violence statewide will be increased.

Activity 1. Identify existing and needed financial resources.

Activity 2. Create a process for soliciting resources.

Activity 3. Implement resource solicitation process.

Activity 4. Evaluate and revise as needed.

Outcome 1.3. The SPT members' expertise will be increased.

Activity 1. Formalize an ongoing expertise needs assessment process utilizing evolving best practices.

Activity 2. Create a plan for developing, acquiring, and maintaining needed expertise.

Activity 3. Implement training to ensure expertise in IPV-SV prevention.

Activity 4. Evaluate and revise the expertise planning and implementation process.

## Rationale for Goal 1

The effectiveness and sustainability of the SPT are critical to the long-term success of the project. This goal will provide the foundation for the project to move forward into implementation of the Prevention Plan. Research has shown that strong leadership is an integral component to the success and stability of any project. In order to increase the effectiveness and sustainability of the SPT, a committee has been established. This Partnerships Committee, with the State Capacity Building Team (SCBT), will be responsible for the implementation and evaluation of Goal One (see Page 72 – Table 3.1).

*Outcome 1.1:* In order to achieve this goal, the leadership of the SPT will be strengthened. Six activities will support the development of SPT leadership.

*Activity 1:* SPT members are committed to the project for a variety of reasons and they bring diverse backgrounds, knowledge, interests, and skills. In order to best serve the project and the SPT members, an assessment of the membership will be conducted. This will allow the pairing of SPT members with the area best suited for their interests and skills. This activity will be completed in 2009 and repeated as needed throughout the life of the project.

*Activity 2:* The SPT will recruit and maintain membership, ensuring that it represents racial, ethnic, and gender diversity within ND. It is important that the SPT is assessed regularly to ensure representation from sectors that will inform the project as it moves forward into implementation. New members may need to be recruited to meet the needs of the project. As well, the needs of the SPT members will also be assessed regularly, to ensure they have the information and tools necessary to be successful. An initial assessment will be completed by the end of 2009 and repeated annually throughout the life of the project.

*Activity 3:* Although there is strong commitment to the SPT by its members, no formal membership structure has been developed. As the project moves forward, Memorandums of Understanding (MOUs) or other statements of commitment will be formalized. This will ensure the commitment to the project goes beyond the individual members, to include the organizations they represent. The Partnerships Committee will create MOUs for organizations participating in this project and have them sign by the end of 2010. This process will be ongoing and formalized to ensure that as new organizations come to the SPT, they sign MOUs when they join.

*Activity 4:* As the SPT is enhanced, a structure will be created to allow for an organized working structure (such as bylaws, organizational charts). To maximize time and resources, the SPT is divided into committees, based on the goals identified in this plan: Partnerships, Data and Innovations Committees. Based on the results of the assessment in Activity 1, SPT members will be identified for these groups. A formalized structure will ensure that even though the teams may diversify and meet independently, the group's cohesiveness built over the past three years is not lost. As stated in Activity 1, the

assessment will be completed by the end of 2009. The structure for the SPT be established and operationalized at the beginning of 2010.

*Activity 5:* The SPT will need to continue to meet on a regular basis in order to achieve the goals set forth in this plan. To ensure the time of SPT members is valued, methods for effective meetings will be implemented and evaluated on a regular basis. Meeting evaluations will be conducted following each meeting and the results reviewed regularly, to make timely adjustments as needed. This development and evaluation will begin immediately and continue throughout the life of the project.

*Activity 6:* As the SPT moves forward, the support of the Local Prevention Teams (LPTs) will be essential to successful the implementation of the plan. As well, the LPTs will require the leadership of the SPT to guide the work in communities. This infusion of the SPT and LPTs will create a synergistic effect across the state. Efforts will be made to integrate the work of the SPT and LPTs at regular meetings, trainings and other events. This ongoing relationship of the SPT and LPTs will be regularly nurtured and assessed throughout the life of the project.

*Outcome 1.2:* As identified in the Needs and Resources Assessment, North Dakota has a wealth of resources available to support primary prevention efforts. In order to achieve the goals set forth in the plan, the SPT will need to tap into those resources through the following four activities.

*Activity 1:* As the project is primarily federally funded through grants, additional funding sources will need to be identified. The Partnerships Committee will examine existing financial resources, to compile a list of potential funders. To ensure that the SPT does not compete with LPTs for funding, state level businesses, institutions and organizations will be highlighted. At the same time, the committee will assess ongoing financial needs to ensure the plan to target potential funders meets the needs of the project. As funding sources and opportunities are constantly changing, this activity will begin in 2010 and will continue throughout the life of the project.

*Activity 2:* In order to solicit resources, a process will be created to allow SPT members access to the necessary tools. This may include the development of the following: a PowerPoint presentation to use with businesses, policymakers, leaders; fact sheets detailing the impact of IPV and SV in ND; cost-benefit analyses to highlight the importance of prevention. The Partnerships Committee will examine existing tools to assist in this process, including “Making the Case for Prevention through a Cost Benefit Analysis” from Transforming Communities (see Page 89 – Table 3.6). It will be important that this activity be completed prior to the next legislative session in 2011.

*Activity 3 & 4:* After the financial resources are identified and a process for soliciting the financial resources is finalized, it will be implemented (Activity 3). How and when it is implemented will be determined in the planning process. To ensure the plan is implemented as intended, ongoing evaluation will be conducted and appropriate revisions made (Activity 4). These activities are dependent on the completion of Activities 1 and 2.

*Outcome 1.3:* As we have learned in our journey through this process, a certain level of expertise is needed in the areas of IPV, SV and primary prevention. A dynamic and evolving field, IPV and SV prevention will require SPT members to develop and maintain their knowledge through the following three activities.

*Activity 1:* An assessment of the needs of SPT will be conducted. This will be combined with the assessment from Outcome 1.1 – Activity 1. Based on the results, training and information will be provided to ensure SPT members are knowledgeable about best practices, as they relate to this project. The initial assessment will be conducted by the end of 2009, with ongoing assessments as needed throughout the life of the project.

*Activity 2 & 3:* To stay on top of developments in the field, a plan will be created for developing, acquiring and maintaining the needed expertise. This plan will be led by NDCAWS/CASAND, NDDoH, and EE staff through the training and technical assistance provided at the national level. As tools, research and other materials are received, they will be distributed to SPT as needed. Training will be implemented as information comes available. As advancements and information are made available on a regular basis, this will be an ongoing process throughout the life of the project.

*Activity 4:* Once a plan is created, it will need to be assessed regularly. To ensure the information provided is not only helpful to SPT members, but also distributed in a manner that suite their needs, evaluations will be conducted of all meetings and trainings. Based on the results of the evaluations, revisions will be made. This activity will begin immediately and continue throughout the life of the project.

**GOAL 1 (Table 3.1):**

**Increase the effectiveness and sustainability of the North Dakota Intimate Partner and Sexual Violence State Prevention Team.**

| Inputs | Strategies/Activities | Outputs | Outcomes |
|---|---|---|---|
| Current SPT and SCBT<br><br>Needs and Resource Assessment<br><br>Goals and Outcomes<br><br>DV/RC Agencies & LPTs<br><br>EMPOWER collaborative & funding<br><br>DELTA collaborative & funding<br><br>Support of ND Governor's Office<br><br>Collaboration between NDCAWS & NDDoH | Activity 1. Ongoing assessment of characteristics of membership needed to accomplish IPV & SV prevention (representation by key groups including organizations and population groups and of the needed skills). | Results of assessment<br>Roster of members<br>Attendance at meetings<br>Satisfaction of members | Outcome 1.1. By 2011, leadership within the SPT will increase, as demonstrated by the structure and coordination of the SPT and its committees. |
| | Activity 2. Recruit and retain members, including ongoing assessment of member needs and development and implementation of strategies for meeting those needs (orientation, etc.) | Orientation packet<br>Attendance at meetings<br>Satisfaction of members | |
| | Activity 3. Formalize membership on SPT through MOUs, statements of commitment. | MOUs and other formal documentation of relationships | |
| | Activity 4. Create structure for the team (such as a governor's council, cabinet position, commission, alliance, Human Relations Commission, 501(c) (3) status), leadership, and committee structure (partnership, innovation and data) | By-laws and other formal documentation of structure of team | |
| | Activity 5. Develop and implement methods for effective meetings, implement, and evaluate. | By-laws and other formal documentation<br>Agendas and minutes of meetings<br>Satisfaction of members<br>Products created at meetings | |
| | Activity 6. Create linkages with regional and local entities, such as linkages between SPT and local LPTs. | Organizational and inter-organizational charts<br>Documentation of shared projects | |
| | Activity 1. Identify existing and needed financial resources. | Plan | Outcome 1.2. By 2011, the SPT will increase resources, as measured by the resources available to support prevention. |
| | Activity 2. Create a process for soliciting resources, including presentations, fact sheets, and cost benefit analyses, in concert with the Data Committee. | Toolkit | |
| | Activity 3. Implement resource solicitation process. | Log of activities | |
| | Activity 4. Evaluate and revise as needed. | Feedback & Revisions | |
| | Activity 1. Formalize an ongoing expertise needs assessment process utilizing evolving best practices. | Plan, including assessment tool and process | Outcome 1.3. By 2011, the SPT will build the expertise necessary to maintain SPT, as demonstrated by a capacity assessment and feedback from SPT members. |
| | Activity 2. Create a plan for developing, acquiring, and maintaining expertise. | | |
| | Activity 3. Implement training to ensure expertise in IPV-SV prevention. | Training conducted | |
| | Activity 4. Evaluate and revise expertise planning and implantation process. | Report, feedback and revisions | |

Goal 2:
Increase the availability of data in ND regarding
intimate partner and sexual violence for planning and evaluation.

Outcome 2.1. By 2016, a state level centralized data center will be operational.

Activity 1. Identify other models of data collection.

Activity 2. Create a ND model, including a data base.

Outcome 2.2. By 2013, there will be increased access to IPV/SV data.

Activity 1. Identify current sources of data.

Activity 2. Work with existing data sources to increase reliability and validity of data.

Activity 3. Develop a surveillance plan.

Activity 4. Establish partnerships to access additional data.

Outcome 2.3. Annually, information regarding IPV and SV is disseminated.

Activity 1. Create a plan for collection, analysis, and dissemination of data.

Activity 2. Collect already existing and new data.

Activity 3. Analyze data and create a surveillance plan.

Activity 4. Write and present results of data collection.

## Rationale for Goal 2

Through the process of conducting the statewide and local community needs assessments, the lack of data emerged as a dilemma. Particularly lacking is data regarding perpetration and perpetrators, what protective factors are important for protecting IPV and SV, and data regarding specific groups (American Indians and lesbian, gay, bisexual and transgendered individuals). In order to increase the availability of data regarding IPV and SV for planning, program development and evaluation, the SPT has established a Data Committee. This committee, with the SCBT, will be responsible for the implementation and evaluation of Goal Two (see Page 76 – Table 3.2).

*Outcome 2.1:* The development of a state level centralized data center will provide the venue for achieving the overall goal. Two activities lead to the development of a data center.

> *Activity 1:* Other states have centralized data centers for IPV and SV, as well as other related health issues. In order to create a system in ND, these models will be identified and the pros and cons of those models in this environment will be brainstormed. This activity will begin in 2010 and continue as new sources become available.
>
> *Activity 2:* Based on lessons learned from other data systems, a model will be designed for ND. This model will include a database to allow for the consistent and accurate collection of data related to IPV and SV in ND. This electronic surveillance database will include existing data, as well as the capacity to include new data as it becomes available. This activity is dependent upon Activity 1 and development will begin upon its completion.

*Outcome 2.2:* Four activities will lead to the increase in the access to IPV/SV data. The data center will include partnerships across organizations, resources for summarizing already existing information into one central location, providing technical assistance to other organizations regarding data collection, and collection of new data.

> *Activity 1:* Currently relevant data is collected independently by various agencies, such as domestic violence and rape crisis centers, law enforcement, mental health and substance abuse, child welfare, and education entities. Initially, sources of data that can be accessed prior to the next legislative session (2011) will be identified. This activity will begin in 2009 and continue as new partnerships are created.
>
> *Activity 2*: In cases where data is being collected, but threats to its reliability and validity have been identified, technical assistance will be provided to increase the quality of data currently being collected. One example of this would be in the data collected by NDCAWS/CASAND and its member programs. As this is an area in which the partnerships are already well developed, this would be a logical place to start. This activity will begin in 2010 and continue as new data partners are established.

*Activity 3:* Through the development of an ongoing surveillance plan, the committee could identify potential sources of data. The longer range intent will be to identify sources of data that are important, but more difficult to obtain.

*Activity 4:* In addition to existing data, new data partnerships will be important to achieve the outcome. In order to access new sources of data, partnerships will need to be created. It will be important to develop agreements, such as memorandums of understanding (MOUs) in order to share data. This activity will begin in 2010 and will continue as new partners are developed through the SPT.

*Outcome 2.3:* Creating methods for sharing data and improving the quality of data are long term. In the meantime, whatever data is currently accessible will be disseminated annually, to inform program and policy development at the local and state levels.

*Activity 1:* A plan for the collection, analysis and dissemination of data will begin in Year 1 of the project. This plan will be done in conjunction with the Activities in Outcome 2.2, through the identification of available data sources. This initial data was also collected over the past few years of the project in the Needs and Resources Assessment for the purpose of this Prevention Plan.

*Activity 2:* Building upon the MOUs established in Outcome 2.2 – Activity 4, the Data Committee will collect existing data from participating organizations. In addition, new data will be collected to meet the needs of project and fill the gaps as identified in the needs assessment. This activity will begin as partners are established and will continue as new partners and data are identified.

*Activity 3:* Methods for sharing information that protect individuals and allows for creation of accurate pictures of the magnitude of the problem, levels of risk and protective factors, and measuring change over time, will be developed. Models for surveillance plans which exist with other projects in North Dakota will be adapted.

*Activity 4:* A dissemination plan created by the EE and the Data Committee will be adapted to guide dissemination initially. As the project continues and feedback is available, both data collection and dissemination procedures will be adapted to increase effectiveness. The first report on data will be in 2010 and will continue annually.

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**GOAL 2 (Table 3.2):**
**Increase the availability of data regarding intimate partner and sexual violence for planning and evaluation.**

| Inputs | Strategies/Activities | Outputs and Initial Outcomes | Outcomes |
|---|---|---|---|
| NDCAWS/CASAND existing data system<br><br>UCR<br><br>Previous surveys, i.e. campus survey<br><br>BRFSS and YRBS<br><br>National interest in creating a national survey re: women and violence<br><br>DoH philosophy about data/ surveillance<br><br>Experience with data, evaluation<br><br>National, state, and local interest in having information to guide decision making | Activity 1. Identify other models of data collection. | Information available for decision making | Outcome 2.1. By 2016, a state level data center will be operational, as demonstrated by a centralized location for data related to IPV/SV. |
| | Activity 2. Create North Dakota model, including data base. | Electronic surveillance data base with existing data and capacity for new data | |
| | Activity 1. Identify current sources of data by fall 2010. | Data available for decision making (i.e. Child Protection, YRBS, BRFSS, Protection and Advocacy, NDCAWS/CASAND/local entities, attorney general's office, DoH (HIV, tobacco), DHS (Substance use), DOT, Safe Communities, DPI) | Outcome 2.2. By 2010, the SPT will increase access to IPV/SV data, as measured by data sources and partners. |
| | Activity 2. Work with existing data sources to increase reliability and validity of data. | Expert review of data sources and data | |
| | Activity 3. Develop surveillance plan. | Plan | |
| | Activity 4. Establish partnerships to access additional data. | MOUs | |
| | Activity 1. Create plan for collection, analysis and dissemination of data. | Plan | Outcome 2.3. Beginning in 2011, information regarding IPV/SV will be disseminated by the SPT, as illustrated by annual data reports. |
| | Activity 2. Collect already existing data and new data. | Data available for analysis | |
| | Activity 3. Analyze data and create surveillance plan. | Surveillance Plan | |
| | Activity 4. Write results and present. | Reports and presentations<br>Information available for decision making | |

Goal 3:
Increase the use of evidence supported and evidence based strategies to prevent intimate partner and sexual violence in North Dakota.

Outcome 3.1. The State Prevention Team (SPT) and Local Prevention Teams (LPTs) will be knowledgeable about strategies for community and organizational development by January 2010.

Activity 1. Identify evidence supported and evidence based strategies.

Activity 2. Create learning opportunities for SPT and LPTs to increase knowledge regarding evidence supported and evidence based strategies.

Activity 3. Create methods for monitoring ongoing learning about strategies for community and organizational development.

Activity 4. Use feedback to revise methods for learning about community and organizational development strategies.

Outcome 3.2. The SPT and LPTs will be knowledgeable about strategies for IPV/SV prevention by January 2010.

Activity 1. Identify evidence supported and evidence based strategies.

Activity 2. Create learning opportunities for SPT and LPTs to increase knowledge regarding evidence supported and evidence based strategies.

Activity 3. Create methods for monitoring ongoing learning about evidence based and evidence supported prevention strategies.

Activity 4. Use feedback to revise methods for learning about evidence based and evidence supported prevention strategies.

Outcome 3.3. LPTs and other organizations across the state will have access to evidence supported and evidence based prevention strategies by January 2010 and ongoing.

Activity 1. Create centralized location, easily accessible, for information about innovative strategies.

Activity 2. Provide technical assistance and monitor the use of strategies.

Activity 3. Use feedback to revise evidence supported and evidence based prevention strategies.

## Rationale for Goal 3

As highlighted in the needs and resources assessment, communities in ND are poised to implement IPV and SV prevention programs. Local Prevention Teams (LPTs) have identified target populations and strategies/activities for both capacity building and a chosen population in their prevention plans. Through the partnership developed between LPTs and the SPT, recommended strategies will be selected for implementation across ND. The SPT will provide the structure and support for implementation at the local level. In order to increase the use of evidence supported and evidence based (ES/EB) strategies for IPV/SV prevention statewide, the SPT has established an Innovations Committee. This committee, with the SCBT, will be responsible for the implementation and evaluation of Goal Three (see Page 80 – Table 3.3).

*Outcome 3.1:* The SPT and LPTs have begun the process of selecting strategies/activities to increase their capacity through the development of prevention plans. In the past five years of DELTA and three years of RPE, communities have learned how important community and organization support for prevention is in determining the progress and success of a project. As research develops in the field of violence prevention, knowledge about best practices will become increasingly important. Four activities will lead to an increase in knowledge about strategies for community and organizational development by 2010.

> *Activity 1:* The SPT and LPTs will work to identify ES/EB strategies for community and organizational development. Some strategies/activities have already been implemented as LPTs have developed over the past years. One strategy that has proven to be successful is the INSTIGATE! Manual by Transforming Communities (see Page 97 – Table 3.6). The Innovations Committee and LPTs will identify additional tools for development. ES/EB strategies will be identified by the end of 2009.
>
> *Activity 2**:*** Once the strategies are identified, it will be important for the SPT and LPTs to increase their knowledge related to such strategies. One way to encourage learning among the SPT and LPTs would be to create opportunities for sharing through training, meetings, and conference calls. In addition, to nurture collective learning, the LPT currently using INSTIGATE! will share their successes, challenges and lessons learned with that strategy. As learning is a dynamic process, it will continue throughout the life of the project.
>
> *Activity 3 & 4:* In order to monitor methods for learning about community and organizational development, an evaluation plan will be created by the EE and reviewed by the SCBT. Based on the results of the evaluations, revisions will be made as needed. All training, meetings and other learning opportunities will be evaluated throughout the life of the project.

*Outcome 3.2:* The SPT and LPTs have begun the process of selecting ES/EB strategies/activities to prevent IPV and SV through the development of prevention plans. As research develops in the field of violence prevention, knowledge about best practices will become increasingly important. Four activities will lead to an increase in knowledge about strategies for IPV and SV prevention by 2010.

*Activity 1:* The SPT and LPTs will work to identify best practices for IPV and SV prevention. These strategies/activities have already been implemented in some form as LPTs have developed over the past years. One strategy that has proven to be successful is the Safe Dates Program (see Page 87 – Table 3.5). The Innovations Committee and LPTs will identify additional tools for ES/EB prevention strategies. Strategies will be identified by the end of 2009.

*Activity 2:* Once the strategies are identified, it will be important for the SPT and LPTs to increase their knowledge related to such strategies. One way to encourage learning among the SPT and LPTs would be to create opportunities for sharing through training, meetings, and conference calls. In addition, to nurture collective learning, LPTs who have implemented strategies/activities will share their successes, challenges and lessons learned. As learning is a dynamic process, it will continue throughout the life of the project.

*Activity 3 & 4:* In order to monitor methods for learning about ES/EB strategies, an evaluation plan will be created by the EE and reviewed by the SCBT. Based on the results of the evaluations, revisions will be made as needed. All training, meetings and other learning opportunities will be evaluated throughout the life of the project.

*Outcome 3.3:* After strategies are identified and knowledge about such strategies has increased, access to the strategies becomes critical. Due to limited resources for prevention, technology will be utilized to bridge the vast rural setting of ND to ensure that all communities have access to strategies, regardless of location or resources. Three activities will lead to the outcome by 2010.

*Activity 1:* The NDCAWS/CASAND website will serve as a centralized location for information about ES/EB strategies. As strategies are identified, they will be made available through the website. As funding permits, NDCAWS/CASAND will have products on hand to share with organizations. The website development has already begun and will be updated regularly as resources are acquired.

*Activity 2:* As communities access information, they will be given the opportunity to request technical assistance around selection and implementation of strategies. Any requests for materials will be documented to track what is being implemented. This activity has already begun and will continue throughout the life of the project.

*Activity 3 & 4:* All technical assistance will be evaluated by the EE and appropriate revisions made. As we learn more about available ES/EB strategies, changes will need to be made. This activity will begin immediately and continue throughout the life of the project.

**GOAL 3 (Figure 3.3):**

**Increase the use of evidence supported and evidence based strategies to prevent intimate partner and sexual violence.**

| Inputs | Strategies/Activities | Outputs | Outcomes |
|---|---|---|---|
| State and local needs assessments<br><br>State and local prevention teams<br><br>DELTA Collaborative<br><br>EMPOWER Collaborative<br><br>Historical collaboration between state and local partners<br><br>Evidence based and evidence supported strategies | Activity 1. Identify evidence supported and evidence based strategies. | List of strategies, with documentation | Outcome 3.1. By 2011, the SPT and LPTs will increase their knowledge about evidence supported and evidence based strategies for community and organizational development, as measured by a survey. |
| | Activity 2. Create learning opportunities for SPT and LPTs to increase knowledge regarding evidence supported and evidence based strategies. | Resources for learning available (webinars, workshops, national conferences, articles, phone conferences) | |
| | Activity 3. Create methods for monitoring ongoing learning about innovative strategies. | Plan for evaluation | |
| | Activity 4. Use feedback to revise methods for learning about innovative strategies. | Evaluation reports<br>Revised prevention strategies | |
| | Activity 1. Identify evidence supported and evidence based strategies. | List of strategies | Outcome 3.2. By 2011, the SPT and LPTs will increase their knowledge about evidence supported and evidence based strategies for IPV/SV prevention, as measured by a survey. |
| | Activity 2. Create learning opportunities for SPT and LPTs to increase knowledge regarding evidence supported and evidence based strategies. | Training calendar | |
| | Activity 3. Create methods for monitoring ongoing learning about innovative prevention strategies. | Plan for evaluation | |
| | Activity 4. Use feedback to revise methods for learning about innovative prevention strategies. | Evaluation reports<br>Increased knowledge | |
| | Activity 1. Create centralized location, easily accessible, for information about innovative strategies. | Materials available through website | Outcome 3.3. By 2010, LPTs and other organizations will have access to evidence supported and evidence based strategies, as measured by the use of technical assistance and resources. |
| | Activity 2. Provide technical assistance and monitor the use of strategies. | Record of use of materials<br>Evaluation report | |
| | Activity 3. Use feedback to revise innovative prevention strategies. | Revised prevention strategies | |
| | Activity 4. Revise and monitor process as needed to meet needs. | | |

Goal 4:
Increase norms and behaviors that prevent intimate partner and sexual violence in North Dakota.

Outcome 4.1. Children and youth will experience increased safety in schools in North Dakota.

Activity 1. Obtain bullying prevention program for implementation in schools.

Activity 2. Implement programs with fidelity to the model.

Activity 3. Based on positive initial outcomes, expand implementation and make program available for other communities.

Outcome 4.2. Youth will experience increased healthy relationships.

Activity 1. Obtain IPV/SV prevention program for implementation in schools.

Activity 2. Implement Programs with fidelity to the model.

Activity 3. Based on positive initial outcomes, expand implementation and make program available for other communities.

Outcome 4.3. Social norms that perpetuate intimate partner and sexual violence in North Dakota will decrease.

Activity 1. Assess social norms in ND related IPV/SV.

Activity 2. Identify existing social marketing campaigns related to the reduction of social norms that perpetuate IPV/SV, based on the results of the survey.

Activity 3. Implement social marketing campaign.

Activity 4. Evaluate and revise, as needed.

## Rationale for Goal 4

In conjunction with Goal 3, the Innovations Committee will work to increase norms and behaviors that prevent intimate partner and sexual violence in ND. Actual implementation for this goal will be in local DELTA/RPE funded communities (see Page 85 – Table 3.4). Although we admit that a goal around social norms may be a lofty one, it is essential to the community response to the prevention of, as well as the effective intervention to intimate partner and sexual violence. Community beliefs about violence, as highlighted in the needs assessment, are at the core of the theoretical basis of what contributes to and perpetuates violence in our society. In order to counteract these social norms to create communities where violence is unacceptable, a variety of efforts will be implemented at state and local levels.

Through the development of the Local Prevention Teams (LPTs) Prevention Plans, target populations and strategies were chosen based on the needs and resources of the local communities participating in this project. Building upon the knowledge developed in Goal 3, LPTs will have the foundation in their community, as well as the support of the State Prevention Team (SPT) to implement these strategies for optimal impact to decrease tolerance of intimate partner and sexual violence in North Dakota.

*Outcome 4.1:* Three activities will be combined to increase the safety of children and youth in schools. As highlighted in both state and local needs and resources assessments, bullying is an ongoing issue in schools across ND. Research indicates a link between bullying and IPV/SV.

> *Activity 1:* Through the work in Goal 3, as well as the development of prevention plans, LPTs will obtain ES/EB bullying prevention programming to be implemented. One such program is the Olweus Bullying Prevention Program (see Page 87 – Table 3.5). As funding permits, NDCAWS/CASAND will make programs available to LPTs for implementation in their communities. This activity will be completed by the end of 2009, with implementation to follow in 2010.
>
> *Activity 2:* After the program is selected, it will need to be implemented with fidelity to the model. To ensure effective implementation, contextual and capacity issues need to be taken into account. Based on those issues, appropriate adaptations will be made. Process evaluation will be conducted throughout the implementation, as well as outcome evaluation, both by the EE with the support of the LPT. Implementation will begin in 2010 and continue throughout the life of the project.
>
> *Activity 3:* Based on positive results of the process and outcome evaluations, program implementation will be expanded to additional populations and made available to other communities. As results related to outcomes will take time, this activity will be determined by the evaluation of the program.

*Outcome 4.2:* Three activities will be combined to increase healthy relationships for youth. As highlighted in local prevention plans and supported by research, the development of healthy relationships is a key component to the prevention of IPV and SV in youth.

*Activity 1:* Through the work in Goal 3, as well as the development of prevention plans, LPTs will obtain an ES/EB IPV/SV prevention program, focusing on healthy relationships, to be implemented in schools. Examples of such programs are Expect Respect and Safe Dates (see Page 87 – Table 3.5). As funding permits, NDCAWS/CASAND will make programs available to LPTs for implementation in their communities. This activity will be completed by the end of 2009.

*Activity 2:* After the program is selected, it will need to be implemented with fidelity to the model. To ensure effective implementation, contextual and capacity issues need to be taken into account. Based on those issues, appropriate adaptations will be made. Process evaluation will be conducted throughout the implementation, as well as outcome evaluation, both by the EE with the support of the LPT. Implementation will begin in 2010 of the project and continue throughout the life of the project.

*Activity 3:* Based on positive results of the process and outcome evaluations, program implementation will be expanded to additional populations and made available to other communities. As results related to outcomes will take time, this activity will be determined by the evaluation of the program.

*Outcome 4.3:* A key component in the prevention of IPV/SV is understanding the social norms that support these issues in ND. In understanding these norms, we can begin to plan campaigns to decrease negative norms and increase positive ones. Four activities will support a social norm campaign.

*Activity 1:* Further understanding of the social norms that contribute to IPV and SV will guide the development of activities/strategies. An assessment tool will be developed by the EE, with input from the SPT and LPTs. Specifically, the LPTs that conducted community surveys as a part of their needs assessment will provide expertise and guidance based on their lessons learned. The assessment will be conducted in 2010 in order to allow time for the development of strategies/activities to increase positive social norms.

*Activity 2:* Based on the social norms highlighted through the results of the survey, the Innovations Committee will identify existing social marketing campaigns related to the reduction of social norms that contribute to IPV and SV. A social marketing campaign will be selected through the work of this Committee and supported by the SPT and LPTs based on its ability to affect the norms and its fit within communities in ND. Appropriate adaptations will be made, as necessary. This activity will begin in 2011, with implementation to follow.

*Activity 3:* With the support of the SPT, LPTs will implement the social marketing campaign. ND is a rural state with limited media markets, assisting in the blanketing of all communities across ND. As the SPT works with state level markets and LPTs work with local markets, saturation of positive social norms supportive of the reduction of IPV and SV will occur. This activity is heavily based on a variety of activities at both state

and local levels, so the timeline is more difficult to determine. It is preferred that the implementation of the social marketing campaign begin as soon as possible.

*Activity 4:* The EE will conduct process and outcome evaluations throughout the development and implementation of the social marketing campaign. Appropriate revisions will be made.

**GOAL 4 (Table 3.4):**

## Increase norms and behaviors that prevent intimate partner and sexual violence in North Dakota.

| Inputs | Strategies/Activities | Outputs | Outcomes |
|---|---|---|---|
| State and local needs assessments<br><br>State and local prevention teams<br><br>Historical collaboration between state and local partners<br><br>Evidence supported and evidence based strategies | Activity 1. Obtain bullying prevention program for implementation in schools (*Olweus Bullying Prevention Program*). | Programs available | Outcome 4.1. By 2012, children and youth will experience increased safety in schools, as measured by successful implementation of bullying prevention programs. |
| | Activity 2. Implement Program with fidelity to the model. | Process evaluation report<br>#s of persons impacted | |
| | Activity 3. Based on positive initial outcomes, expand implementation and make program available for other schools/communities. | Revised programs<br>Record of use | |
| | Activity 1. Obtain IPV/SV prevention program for implementation in schools (*Safe Dates – Expect Respect – Healthy Relationships*). | Programs available | Outcome 4.2. By 2012, children and youth will experience increased healthy relationships, as measured by successful implementation of IPV/SV prevention programs. |
| | Activity 2. Implement Program with fidelity with the model. | Process evaluation report<br>#s of persons impacted | |
| | Activity 3. Based on positive initial outcomes, expand implementation and make program available for other schools/communities. | Revised programs<br>Record of use | |
| | Activity 1. Assess social norms in ND related IPV/SV. | Survey<br>Report | Outcome 4.3. By 2012, social norms that perpetuate IPV/SV will decrease, as measured by a survey. |
| | Activity 2. Identify existing social marketing campaigns related to the reduction of social norms that perpetuate IPV/SV, based on the results of the survey. | Campaign | |
| | Activity 3. Implement social marketing campaign. | #s of persons impacted | |
| | Activity 4. Evaluate and revise, as needed. | Evaluation report<br>Revised campaign | |

## Recommended Strategies

Through the work of the State Prevention Team and Local Prevention Teams, a list of recommended strategies has been compiled (see Page 87 – Table 3.5). These are strategies that have evidence to support their effectiveness to prevent IPV and SV. Evidence supported strategies for community and organizational development are listed in Table 3.6 (Page 89). In addition, programs that have shown promise are listed in Table 3.7 (Page 91). Although these programs do not have evidence to show they prevent IPV and SV, they have strong components and could be used to enhance evidence based programming.

Primary prevention, related to IPV and SV, are relatively new fields. Through the work of DELTA, EMPOWER and RPE, new strategies for IPV/SV prevention will be identified. Lessons learned from other public health issues can inform the work of IPV/SV prevention. One way to do this is to examine the components of successful programming and apply them to the IPV/SV field.

It is important to understand the concepts of Getting to Outcomes (GTO) and the framework it provides for planning, implementation and evaluation of prevention programming. GTO, or another planning process, provides the framework to select programming that best fits the needs of a community. Not every program will work in every community; just because a program works in one community, does not ensure success in all communities. Therefore, a thorough planning process, such as GTO, is recommended.

Table 3.5. *Evidence Supported and Evidence Based Programs for Prevention of IPV and SV*

| Program | Program Description | Target Audience | Curriculum Components |
|---|---|---|---|
| **Expect Respect**<br><br>SafePlace Institute | A school-based program for prevention teen dating violence and promoting safe and healthy relationships. Expect Respect is a curriculum for middle and high schools that engages the entire school community in changing social norms about dating violence in relationships and creating a respectful environment.<br>*www.safeplace.org* | Middle school<br>High school | Learning about healthy relationships requires practicing healthy relationships. Expect Respect is based on an active and experiential learning process. Creative activities in all program components engage youth in exploring their experiences and beliefs and taking a stand against violence. Expect Respect provides opportunities to teach youth to develop strong, positive relationships with peers and adults, which is key to effective violence prevention programs<br>*Nation et al. 2003* |
| **Fourth "R"**<br><br>Strategies for Healthy Youth Relationships: Centre for Prevention Science - University of Toronto | The Fourth R consists of a comprehensive school-based program designed to include students, teachers, parents, and the community in reducing violence and risk behaviors. It is important that young people be given information that will help them make good decisions, and are shown positive relationship models that will demonstrate alternatives to the negative examples they frequently see in the world around them.<br><br>www.youthrelationships.org | Middle school<br>High school | The program is taught in the classroom, using a thematic approach to reduce risk behaviors including: violence/bullying; unsafe sexual behavior; substance use. In addition to the classroom component, the Fourth R seeks to involve the school and community in delivering positive messages to youth. Teachers are engaged through the delivery of the program. Students are engaged through active learning, peer mentoring, and role modeling of appropriate behaviors. Parents are engaged through outreach and communication about the program. Finally, these strategies build bridges between community agencies and the school community. |
| **MOST Clubs**<br><br>Men Can Stop Rape | Programming for mobilizing high school and college men to prevention sexual and dating violence.<br><br>*www.mystrength.org* | Middle school<br>High school<br>Males only | Employing a 16-week curriculum, MOST Clubs inspire members to build and embrace individualized definitions of manhood in ways that promote health, safety, and equality for all. |

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| **SAFE-T**<br><br>Sexual Abuse Free Environment for Teens<br><br>Prevent Child Abuse – Vermont | SAFE-T is a health education program for middle school students that promotes victim/ perpetrator prevention by helping students identify factors that put them at risk for being hurt and hurting others, while fostering the development of protective factors and resilience.<br><br>*www.pcavt.org* | Middle school | By taking a comprehensive approach, the program aims to provide early adolescents with the skills necessary to make healthy choices and form healthy relationships with peers and adults. SAFE-T is highly experiential, and actively involves students in practicing and developing skills related to communication, empathy, self-esteem, healthy coping skills, self-awareness, trust and accountability. |
| **Safe Dates**<br><br>Hazelden | A school-based adolescent dating abuse prevention program. Safe Dates helps teams recognize the difference between supportive relationships and controlling, manipulative, or abusive relationships.<br>*www.hazelden.org* | Middle school<br>High school | The nine-Session *Safe Dates* curriculum, which can be delivered in as few as four sessions, includes cost-saving reproducible student handouts. Highlights of the curriculum include a dating bingo game to help young people identify desirable traits in dating partners and a play on dating abuse that was written by students. |
| **Bullying Prevention Program**<br><br>Olweus<br>Hazelden | A school-based bullying prevention program designed to improve peer relations and make school safer, more positive places for students to develop. Goals of the program include: Reducing existing bullying; prevention new bullying problems; and achieving better peer relations at school.<br>*www.olweus.org* | Elementary School | Bullying Prevention Program is a long-term, system-wide program for change involving program components at four levels:<br>• School-Level Components<br>• Individual-Level Components<br>• Classroom-Level Components<br>• Community-Level Components |
| **Healthy Relationships**<br><br>Men For Change<br>Halifax, NS | Healthy Relationships was developed by a community-group, Men for Change. The goal of the program is to promote gender equity and to end violence in society through the acquisition of knowledge, skills and changes in attitudes.<br><br>http://www.m4c.ns.ca/news.html | Middle school<br>Boys & Girls | The three-part curriculum, dealing with aggression, gender equity, media awareness, and forming healthy relationships, was designed to address factors that contribute to violent behavior, such as gender inequality, power and control. The Healthy Relationships program is intended to complement existing health curricula. |

Table 3.6. *Evidence Supported Tools for Community Development*

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|---|---|---|---|
| **Transforming Communities INSTIGATE!**<br><br>Marin Abused Women's Services | This carefully selected set of tips, tools and exercises to start up a Community Action Team (CAT) in your neighborhood, city, faith-based group, school or place of employment. This toolkit is designed primarily for use by domestic violence and public health organizations that have the staff, structure and resources needed to launch a community mobilization campaign<br><br>*www.transformcommunities.org* | Community Mobilization | Each of the nine INSTIGATE! modules include an Introduction page and several practical tools that you can access by clicking on the Tips and Tools buttons. The first three modules (I, N and S) contain tools to help your team flesh out its vision, recruit new members and start to build teamwork. The next four modules (T, I, G, and A) focus in on practical action planning, developing outreach skills and learning to use media to get your message out and to gain publicity for community events. The last two modules (T and E) offer examples of successful mobilizing campaigns and tools for evaluating the impact of your team's efforts. |
| **Making the Case for Domestic Violence Prevention Through the Lens of Cost-Benefit**<br><br>Marin Abused Women's Services | This Manual was created to help domestic violence practitioners make the case that their prevention programs are valuable and worthy of public and private investment.<br><br>*www.transformcommunities.org* | Resource Development | In an environment of limited funds for social programs, prevention advocates need to be able to convince funders, policy-makers and the community at large that our prevention programs are ***effective and efficient*** – that these programs are improving people's lives in specific, measurable, and cost-effective ways. |
| **Tri-Ethnic Center for Prevention Research**<br><br>Department of Psychology Colorado State University | The Community Readiness Model is an innovative method for assessing the level of readiness of a community to develop and implement prevention programming. It can be used as both a research tool to assess distribution of levels of readiness across a group of communities or as a tool to guide prevention efforts at the individual community level.<br><br>*http://www.triethniccenter.colostate.edu/communityreadiness.shtml* | Community Readiness/ Development | The Community Readiness Model includes:<br>• Nine stage, multi-dimensional model<br>• Facilitates community-based change<br>• Community-specific<br>• Builds cooperation among systems and individuals<br>• Road map for the community development journey |

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| **The Community Toolbox**<br><br>University of Kansas | The purpose of the Community Tool Box is to build capacity for this work—to make it easier for people to bring about change and improvement in their communities. The CTB connects people with resources for learning the many skills required for this work and applying this knowledge in diverse cultures and contexts.<br>http://communityhealth.ku.edu/ | Capacity Building | The CTB mission is to promote community health and development by connecting people, ideas, and resources. After over 10 years of development, the CTB has over 7,000 pages of how-to information relevant to 16 core competencies (e.g., building partnerships, assessing community needs and resources, planning, leadership, intervention, advocacy, evaluation, sustaining the work). |

Table 3.7. *Additional Resources to Enhance Evidence Based Programming*

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| ACT Against Violence<br><br>American Psychological Association | The ACT Project is one of the few violence prevention programs that start with the youngest in our population—children aged 0 to 8 years old—by addressing the adults who are the closest to them. ACT provides adults with the knowledge and skills to help young children grow and learn in a positive, nonviolent environment.<br><br>*www.actagainstviolence.org* | Parents<br>Teachers<br>Adults | The ACT Against Violence Campaign can help communities raise awareness that adults can take action in their own homes, schools, and community to protect children from violence. The campaign includes television, radio, print, and outdoor advertisements. The messages remind parents, teachers, and other caregivers that children learn from what they see and hear. Exposing children to violence and using violence to solve problems teaches children to do the same. |
| Coaching Boys into Men<br><br>Family Violence Prevention Fund | Playbook developed by coaches for coaches. The playbook is designed to help coaches extend valuable teaching to include healthy respect for women and the values present in a strong, nonviolent relationship.<br><br>*www.endabuse.org* | Coaches of male athletes of any age | Boys need role models; they need mentors, teachers, and coaches to give them guidance that will help them grow into healthy young men. They need to know, that in the long run, who they are in society is more important than who they are as a player. |
| Choose Respect<br><br>Centers for Disease Control and Prevention | CR is a national initiative to help youth ages 11-14 form healthy relationships to prevent dating abuse before it starts. It can be used in conjunction with other violence prevention programming – like Expect Respect.<br><br>*www.chooserespect.org* | Adolescents<br>Age 11-13 | The initiative reaches out to youth in this age group because they are still forming attitudes and beliefs that will affect how they are treated and how they treat others. CR also connects parents, teachers, youth leaders and other adults who influence the lives of youth. The way youth act and treat each other is often a reflection of adults' actions. Healthy relationships are built on a foundation of respect. |

**Principles of Effective Prevention**

Even though research in the area of IPV/SV Prevention is limited, decisions about programming can be made based on what has been proven to work in other health-related fields. The article "Applying the Principles of Prevention: What Do Prevention Practitioners Need to Know about What Works?" (Nation, Keener, Wandersman & DuBois, 2005) provides the framework to assess existing programs, based on information compiled after a review of successful prevention programs. These nine principles were determined to be important factors to the success of prevention projects. The hope is that by incorporating these principles into programming will increase the likelihood of success.

- Comprehensive
- Varied Teaching Methods
- Sufficient Dosage
- Theory Driven
- Positive Relationships
- Appropriately Timed
- Socio-Culturally Relevant
- Outcome Evaluation
- Well-Trained Staff

The worksheet below was developed to assist programs in assessing whether existing programming had the essential components proven to be effective in prevention work. Based on the article, it not only includes on the principles buy also questions to ask while reviewing existing programming or selecting a new program to implement.

| | | |
|---|---|---|
| COMPREHENSIVE<br>Strategies should include multiple components and affect multiple settings to address a wide range of risk & protective factors of the target population. | | |
| Does the program include multiple components? | YES<br>NO | |
| Does the program provide activities in more than one setting? | YES<br>NO | |
| Do the activities happen in settings related to the risk and protective factors? | YES<br>NO | |
| VARIED TEACHING METHODS<br>Strategies should include multiple teaching methods, including some type of active, skill-based components. | | |
| Does the program include more than one teaching method? | YES<br>NO | |
| Does the strategy include interactive instruction for practicing new behaviors? | YES<br>NO | |

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| Does the strategy provide hands on learning experiences, rather than passive instruction? | YES NO | |
| SUFFICIENT DOSAGE<br>Participants need to be exposed to enough of the activity for it to have an effect. | | |
| Does the strategy provide more than one session? | YES NO | |
| Does the strategy provide sessions long enough to present the content? | YES NO | |
| Does the intensity of the activity match the level of risk of the participants? | YES NO | |
| Does the strategy include a schedule for follow-up or booster sessions? | YES NO | |
| THEORY DRIVEN<br>Preventative strategies should have scientific justification or logical rationale. | | |
| Does the program provide a theory of how the problem behaviors develop? | YES NO | |
| Does the program articulate a theory of how and why the intervention is likely to produce change? | YES NO | |
| Based on the model of the problem and the model of the solution, do you believe the program is likely to produce change? | YES NO | |
| POSITIVE RELATIONSHIPS<br>Programs should foster strong, stable, positive relationships between children and adults. | | |
| Does the program provide opportunities for parents and kids to strengthen relationships? | YES NO | |
| For situations where parents are not available (or in addition to parents) or relevant, does the strategy offer opportunities for a participant to | YES NO | |

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| develop a strong connection with an adult mentor? | | |
| Does the strategy provide opportunities for the participant to establish close relationships with people other than professional service providers? | YES<br>NO | |
| APPROPRIATELY TIMED<br>Program activities should happen at a time (developmentally) that can have maximum impact in a participant's life. | | |
| Does the strategy happen before participants develop the problem behavior? | YES<br>NO | |
| Is the strategy timed strategically to have an impact during important developmental milestones related to the problem behavior? | YES<br>NO | |
| Does the activity content seem developmentally (intellectually & cognitively) appropriate for the target population? | YES<br>NO | |
| SOCIO-CULTURALLY RELEVANT<br>Program should be tailored to fit within cultural beliefs and practices of specified groups, as well as local community norms. | | |
| Does the strategy appear to be sensitive to social & cultural realties of participants? | YES<br>NO | |
| If not, are you capable of making the changes that are needed to make it more appropriate? | YES<br>NO | |
| Is the strategy flexible to deal with special circumstances or needs of potential participants? | YES<br>NO | |
| Is it possible to consult with potential participants to help you evaluate and/or modify the strategy? | YES<br>NO | |

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| OUTCOME EVALUATION<br>A systematic outcome evaluation is necessary to determine whether a program or strategy worked. | | |
| Is there a plan for evaluating the program? | YES<br>NO | |
| Does the evaluation plan provide feedback prior to the end of the program? | YES<br>NO | |
| Is there a plan for receiving feedback throughout the program development & implementation? | YES<br>NO | |
| WELL-TRAINED STAFF<br>Programs need to be implemented by staff who are sensitive, competent, and have received sufficient training, support & supervision. | | |
| Is there sufficient staff to implement the program? | YES<br>NO | |
| If so, has the staff received sufficient training and supervision and support to implement the program properly? | YES<br>NO | |
| Will efforts be made to encourage stability and high morale in staff members who will provide the program? | YES<br>NO | |

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