Domestic & Sexual Violence: A Background Paper on Primary Prevention Programs and Frameworks

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Suggested Citation

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2012 Shift: The Project to End Domestic Violence
www.preventdomesticviolence.ca
Foreword

Domestic violence is a costly and pervasive social problem that causes untold pain and loss to victims, witnesses and bystanders in every community. While Alberta has already made significant gains by supporting strong leadership and a co-ordinated, community response around domestic violence, more is needed.

Domestic violence is often seen as a problem that can’t be solved. But that’s because prevention is rarely approached with the level of commitment and attention required for long-term success. In fact, domestic violence is preventable, but its prevention requires an informed investment of resources, people, leadership and commitment. Primary prevention efforts must be research-based and seek to promote healthy relationships by reducing factors associated with violent behaviour (risk factors) and strengthening factors that support positive behaviours (protective factors). It also means shifting the focus from a specific person or potential perpetrator, to entire populations and communities by changing attitudes, community norms and behaviours.

As a result, this report, prepared in January, 2011, was designed to review local, national and international evidence regarding the factors causing domestic violence, as well as models of good practice designed to prevent it. An associated aspect of this research was to identify other jurisdictions working in the area of domestic violence primary prevention, and to understand the evidence-based prevention frameworks currently being used.

In the 18 months since our initial scan, there has been a growing body of literature added to the emerging knowledge base in this area. For example: The Centers for Disease Control and Prevention released findings from their 2010 National Intimate Partner and Sexual Violence Survey (Black et al., 2011); Ontario released its Sexual Violence Action Plan (Ontario Women’s Directorate, 2011); and seminal reports such as Engaging Men and Boys to Reduce and Prevent Gender-Based Violence (Minerson, Carolo, Dinner, & Jones, 2011) have all contributed to advancing thinking in how prevention of domestic violence is possible. These are but a few of the many initiatives in this area that contribute to our continued understanding of the scope of the problem and promising models of primary prevention.

It is hoped that efforts to build knowledge in this area continue. Much more research needs to be done to get underneath this complex social issue, to make sense of what is causing it to reach epidemic proportions, and to identify promising practices, services, policies and strategies that reduce and ultimately prevent them from occurring altogether.
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1.0 Introduction

Over the last 30 years, tremendous strides have been made to combat domestic and sexual violence internationally, nationally and locally. The women’s movement, in response to the immediate needs of women and families affected by such violence, has worked hard in the past three decades to create shelters and safe houses, strengthen legal and medical services, as well as bringing awareness to a formally hidden issue (Cohen, Davis, & Graffunder, 2006). This work has been critical, and as a result of these efforts, more victims are protected during crisis periods, there are more criminal justice interventions and relevant organizations have included more comprehensive programming to address the variety of needs women face. This programming goes beyond simply offering a safe haven from violence, but rather addresses an array of issues such as finances, job assistance, legal advocacy as well as offering programs for perpetrators.

These strategies to address the impacts of violence have laid the groundwork for what is currently emerging—the urgency for the development of primary prevention strategies that stop domestic and sexual violence before it even begins (Graffunder, Noonan, & Cox, & Wheaton, 2004; Prevention Institute, 2006, 2007; VicHealth, 2007; Harvey, Garcia-Moreno, & Butchart, 2007; WHO, 2010). Two decades ago, the terms “violence” and “prevention” were not words used together (Centers for Disease Control and Prevention, 2004). However, with domestic and sexual violence being prevalent issues worldwide, the need to “go upstream” in order to address them has become more apparent than ever (WHO, 2010). The idea that violence is preventable has gained considerable momentum in many arenas (Centers for Disease Control and Prevention, 2004; VicHealth, 2007; Harvey et al., 2007; WHO, 2010). With the commitment to address the issue comes the realization that efforts must span a range of arenas—individuals, organizations, communities and governments must work together in order to truly effect change.

Shift: The Project to End Domestic Violence was initiated by the Brenda Strafford Chair in the Prevention of Domestic Violence, in the Faculty of Social Work, at the University of Calgary. Shift is a ground-breaking initiative aimed at significantly reducing, and eventually ending, domestic violence in Alberta. The name Shift represents the spirit of this innovative project designed to create transformational change using a primary prevention approach to stop first-time victimization and perpetration of domestic violence. In short, primary prevention means taking action to build resilience and prevent problems before they occur.

The purpose of Shift is to enhance the capacity of policy makers, systems leaders, clinicians, service providers and the community at large, to significantly reduce the rates
of domestic violence in Alberta. We are committed to making our research accessible and working collaboratively with a diverse range of stakeholders, to inform and influence current and future domestic violence prevention efforts, through the perspective of primary prevention.

As part of a series of Shift research activities, this report focuses specifically on domestic violence (DV) and sexual violence (SV), and does not include information on other forms of violence such as community violence, street violence, suicide or child abuse and neglect. The report provides an overview of domestic violence and prevention definitions, risk and protective factors, and focuses particular attention on the domestic and sexual violence primary prevention frameworks being developed locally, nationally and internationally. In addition, the report provides a brief overview of relevant evidence-based practices in violence reduction. Points of consideration are offered in each section, allowing further reflection of the information in consideration of Alberta’s local context.

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1 While the current trend in the international literature is to use intimate partner violence (IPV), this report uses the term domestic violence in order to keep with the current context in Alberta. See the section “Definitions and Concepts” for further details.
2.0 Methods

In this paper, an overview of promising programs, initiatives and frameworks for the primary prevention of Domestic Violence (DV) and Sexual Violence (SV) are presented. Frameworks from five countries were reviewed: Australia, England, Ireland, Sweden and the U.S. These five were targeted due to their relative similarity to Canada.

A review of both published and unpublished national and international reports, documents and articles was undertaken with the objectives of identifying:

- Evidence of risk and protective factors for DV and SV
- Existing frameworks for the primary prevention of DV and SV
- Evidence for interventions that are effective in the primary prevention of DV and SV

There were two main search strategies employed:

- Database searches employing particular search terms in this area from 2004-2010.\(^2\) The databases searched included Sociological Abstracts, Social Work Abstracts, Social Services Abstracts, SocINDEX and CINAHL. Search terms included \textit{violence prevention}, \textit{domestic violence primary prevention}, \textit{domestic violence} and \textit{primary prevention}. Additional searches were used to examine risk and protective factors related to domestic and sexual violence.
- Searches of over 50 government, non-government and research institute websites for additional articles and reports.

Given the finite time and resources available and the large amount of relevant literature in the field of domestic and sexual violence, the review focused mainly (although not exclusively) on existing reviews (rather than literature reporting evidence from a single study or intervention). Reviews are defined as:

- Papers and/or reports based on community/expert consultation
- Policy/background papers and reports that synthesize approaches to primary prevention
- Publications that review the theory and/or evidence for specific determinants/prevention/intervention strategies

It should be noted that due to the differences in DV and SV definitions and ways of counting between countries and jurisdictions, it is not always the case that comparisons

\(^2\) Sources earlier than 2004 were not those generated by the database searches; rather they were background documents provided to the author from outside sources or those found through website searches.
are of like nature. This review was focused on the primary prevention of domestic and sexual violence between dating, co-habitating, married or ex-partners. This excluded searches on: elder abuse; violence occurring in the family beyond married, ex, co-habitating or dating partners; bullying and child abuse and maltreatment. Additionally, promising domestic or sexual violence interventions considered tertiary in nature were excluded from this review.
3.0 Definitions and Concepts

Before exploring primary prevention possibilities of DV and SV, there is a need to understand the many different ways this issue is understood. Throughout the literature, various terms and definitions are seen. Depending on the source, terms such as “spousal abuse,” “domestic abuse,” “domestic violence,” “spousal assault,” “family violence” and “spousal violence” can all be found with varying definitions. In fact, the Centers for Disease Control and Prevention make the case that a consistent definition is needed in order to properly monitor the incidence of DV and examine trends over time (Centers for Disease Control and Prevention, 2008). A consistent definition also helps researchers measure the risk and protective factors in a uniform manner, which ultimately supports prevention and intervention efforts. This need for a consistent definition is supported by Murray & Graybeal (2007) in their methodological review of domestic violence prevention research. They found that there are no universally accepted definitions of the terms domestic violence, intimate partner violence and domestic violence.

3.1 Concepts in the Literature

In reviewing the literature, the term interpersonal violence is the broadest term, defined simply as violence occurring between individuals either known or unknown to one another (VicHealth, 2007). It is distinguished from collective violence and self-directed violence (such as suicide), and is a gender neutral term for violence between individuals.

More specifically, the term violence against women includes all acts of violence that are both criminal and non-criminal (Castelino & Whitzman, 2008). It is understood to occur on a continuum of economic, psychological and emotional abuse through to physical and sexual violence (VicHealth, 2007). It covers physical, psychological and sexual harm to women specifically because of their gender, and occurs in both public and private domains (Castelino & Whitzman, 2008; VicHealth, 2007).

Within the term violence against women there are a number of other concepts including: intimate partner violence; family violence; domestic violence; and sexual violence. Most frequently used in the current literature is the term intimate partner violence. It has been used to include unmarried couples, as well as both heterosexual and homosexual relationships. Overall, the use of intimate partner violence has largely overtaken the use of domestic violence or spousal abuse (Cohen, Davis, & Graffunder, 2006; Moloughney, 2007; Murray & Graybeal, 2007; Noonan & Charles, 2009; Smith & Straus, 2003; Harvey et al., 2007; WHO, 2010).

Family violence is used by some jurisdictions as it emphasizes violence occurring within relationships (i.e., child abuse, elder abuse and sibling abuse). For example, the Alberta
Government, in its document *Taking Action on Family Violence and Bullying: Report to Albertans* uses the term *family violence*. It is defined as the abuse of power within relationships of family, trust or dependency that endangers the survival, security or well-being of another person (Government of Alberta, 2008). This definition is quite broad, encompassing spousal abuse along with other forms of violence such as elder abuse, child abuse and neglect, and child sexual abuse. The Victorian Government (Australia) also reports that for Victorian Indigenous communities, this term is preferred to others as it communicates that violence can involve and affect the wider family and community (VicHealth, 2007).

*Domestic violence* is utilized by many governments and non-government organizations as it contrasts the violence within the home to violence occurring in the community or workplace (Casetlino & Whitzman, 2008). Both the province of Nova Scotia, Canada and the Home Office in the U.K. use the term *domestic violence* in their violence intervention and prevention frameworks (Debbonaire & Sharpen, 2008; Nova Scotia Domestic Violence Prevention Committee, 2009). Edleson (2000) notes that the definition of domestic violence varies widely, depending on the degree to which non-physical abuse is included. It has also been described as a subset of intimate partner violence, as it is often limited to the violence occurring between married and co-habitating couples.

Domestic violence (DV) is defined differently throughout the literature. There are three different definitions of DV worth noting, each emphasizing a different nuance. For the Home Office in the U.K., the definition emphasizes the potential financial, emotional and sexual aspects of the violence. The Department of Health and Human Services in the U.S. emphasizes that the violence is used by “adults or adolescents” against their intimate partners (Department of Health and Human Services, 2008). For the Nova Scotia Prevention Committee, DV is defined as “deliberate and purposeful violence, abuse and intimidation perpetrated by one person against another in an intimate relationship. It occurs between two persons where one has power over the other, causing fear, physical and/or psychological harm. It may be a single act or a series of acts forming a pattern of abuse” (Nova Scotia Domestic Violence Prevention Committee, 2009, p. 4).

Sexual violence (SV) occurs not only within the context of DV, but also outside of intimate relationships with women at substantially greater risk of victimization than men. It includes any completed or attempted sex act against the victim’s will or involving a victim who is unable to consent, abusive sexual contact and noncontact sexual abuse, including sexual harassment and stalking (Graffunder et al., 2004). The WHO includes in its definition acts to traffic against a person’s sexuality through the use of coercion, threats of harm or physical force by any person regardless of the relationship to the victim in any setting, including but not limited to home and work (Harvey et al., 2007).
Healthy relationships is an important concept within the realm of primary prevention, although definitions for it are few. The Alaskan plan, *Pathways to Prevention*, defines healthy relationships as those that consist of a connection between people that increases well-being, is mutually enjoyable and enhances or maintains each individual’s positive self-concept (Alaska Network on Domestic Violence & Sexual Assault, 2010). It is just as important to define this concept, as educational strategies are often focused on giving young people information on what isn’t healthy.

Shift prefers to use the term domestic violence wherever possible as it encompasses a broad range of behaviours. The Calgary Domestic Violence Committee (CDVC) defines domestic violence as the attempt, act or intent of someone within a relationship, where the relationship is characterized by intimacy, dependency or trust, to intimidate either by threat or by the use of physical force on another person or property. The purpose of the abuse is to control and or exploit through neglect, intimidation, inducement of fear or by inflicting pain. Abusive behaviour can take many forms including: verbal, physical, sexual, psychological, emotional, spiritual and economic, and the violation of rights. All forms of abusive behaviour are ways in which one human being is trying to have control and/or exploit or have power over another. (CDVC, 2012, p. 2)

In this report, distinctions are made between domestic violence and sexual violence.

### 3.2 Prevention of Violence

As mentioned previously, primary prevention has been attracting attention as an effective model for addressing DV and SV. The concept of primary prevention originated in the fields of public and mental health, and has been used to address a range of public health issues (e.g., tobacco use, childhood obesity) (Smithey & Straus, 2003).

*Prevention* is a systematic process that promotes safe, healthy environments and behaviours, thereby reducing the likelihood (or frequency) of an incident, injury or condition from occurring (Cohen, Davis, & Graffunder, 2006).

*Primary prevention* explicitly focuses on action *before* the condition of concern develops. In the area of DV, it means reducing the number of new instances of DV or SV by intervening before any violence has occurred (Harvey et al., 2007). Interventions can be delivered to the whole population or to particular groups that are at high risk of using or experiencing violence in the future. Primary prevention programs are often delivered to large groups in order to reach a cohort within a short time frame (Carmody, 2009).
Secondary prevention in the realm of DV and SV attempts to detect situations where violence is already occurring, but doing so earlier than it might otherwise have been identified (Moloughney, 2007). Generally, this includes immediate responses to violence, such as pre-hospital care or emergency services, as well as efforts to prevent further acts from occurring once violence has been identified (Harvey et al., 2007; WHO, 2010). Secondary prevention is often referred to as “early intervention.”

Tertiary prevention involves providing support and treatment to those already impacted by DV and SV, as well as interventions to reduce the impact of violence once it has been reported. For victims, this includes such strategies as counselling and health care responses while for the perpetrators it includes offender programs and other judicial responses (Moloughney, 2007). The focus here is on reducing the harmful consequences of an act of violence after it has occurred, as well as approaches that focus on the long-term care in the wake of violence, e.g., rehabilitation and reintegration (Harvey et al., 2007; WHO, 2010).

While primary prevention frameworks and strategies are the focus of this paper, it must be stressed that it is not always possible to make clear distinctions between the three types of prevention, and often a robust primary prevention framework will contain elements of secondary or tertiary strategies. For example, policy reform that mandates the arrest of DV perpetrators is a tertiary intervention which may also have a primary prevention effect by communicating to the larger community that violence against women is a serious issue (VicHealth, 2007).

Points to Consider

1. **Definitions matter**: Currently there is too much variance in terms and concepts used. Agreeing to a term and definition is critical to any subsequent attempts to measure the scope of the problem.

2. **Clarity around definitions used and gathering of data**: Definitions used in the research is often different from what is written into criminal codes and monitoring legal interventions of violence. While a specific definition of DV and SV may be adopted for implementation, terms such as spousal assault, spousal battery and sexual assault are all used by criminal codes to categorize legal interventions.

3. **Include multiple manifestations of harm**: Some definitions of DV include sexual, financial and emotional harm while others don’t. It is critical that any definition
includes these above aspects in addition to the physical and psychological manifestation of harm.

4. **Support the exploration of alternate language**: While the terms “perpetrator” and “victim” are used in this document and many others, explore possibilities for alternate language e.g., “survivor of violence.”

5. **Alignment to what currently exists**: Globally, many entities are utilizing the terms “intimate partner” and “sexual violence” to frame the issue. However, alignment with what currently exists locally and nationally may help consistency within a Canadian context.

6. **“Healthy” is an important concept**: Educational strategies are focused on promoting these behaviours. For this reason, defining and using this term is critical in any primary prevention framework.

7. **Use a range of preventions**: Even though the focus is on primary prevention, it is not always possible to clearly distinguish between primary, secondary and tertiary. At times, a tertiary strategy (e.g. legal reform) can achieve a primary effect.
4.0 Violence Against Women: Scope of the Problem

In order to develop any kind of responsive and relevant primary prevention strategy, more than definitions are needed. In many jurisdictions, the issue of violence against women is viewed as a public health issue that requires urgent and immediate attention (Graffunder et al., 2004; Prevention Institute, 2006, 2007; Smithey & Straus, 2003; VicHealth, 2004; VicHealth, 2007). While violence by women against men does occur, it has been widely documented that violence is largely perpetrated by men against women (Domestic Violence Prevention Committee, 2009; Harvey et al., 2007; VicHealth, 2007; WHO, 2010).

Due to the nature of the issue, the occurrence and impacts of violence against women are frequently “hidden,” resulting in an underestimation of the real level of harm caused. Clearly demonstrating the magnitude of the issue of violence against women are the results from a 2004 Australian study commissioned by the Victorian Department of Human Services. This study found that DV alone contributes 7.9 per cent to the disease burden in Victorian women aged 15 to 44, making it the largest known contributor to the preventable disease burden in this age cohort (VicHealth, 2004). Examples of the key health outcomes that make up the substantial disease burden are depression, suicide, tobacco and alcohol use.

4.1 Domestic Violence and Sexual Violence: International

As mentioned previously, terms such as DV and SV (among others) are contained within the greater scope of violence against women. Therefore, any understanding of the scope of the problem is based on research that uses a multitude of terms used in a variety of ways to measure and report on the issue of DV and SV. However, the literature is clear in that most violence against women is perpetrated by a male acquaintance, intimate or other relative (Domestic Violence Prevention Committee, 2009; Harvey et al., 2007; VicHealth, 2007; WHO, 2010).

In Europe, approximately one in five women experience an incident of domestic violence in their lifetime, with one in 10 experiencing an incident of sexual violence (European Commission of Justice, 2010). For European women between the ages of 16-44, DV is the major cause of death and disability (Amnesty International, 2010).

In Australia, one in three women has experienced physical violence since the age of 15, with one in five experiencing sexual violence since the age of 15. In regards to domestic violence, 16 per cent of women have experienced violence by a current or previous partner since the age of 15.
In the U.S., a report released in 2010 indicated that one in four women and one in seven men surveyed were victims of severe physical violence by an intimate partner, and that approximately 1.3 million women were raped in the year preceding the study (Black et al., 2011).

In a similar study completed in 2000, it was found that nearly two-thirds of women who reported being raped, physically assaulted or stalked since the age of 18 were victimized by a current or former husband, co-habitating partner or boyfriend (Graffunder et al., 2004). In 2005 in the United States, more than 1,100 women died as a result of domestic violence (Centers for Disease Control and Prevention, 2009).

According to a study by WHO released in 2005, 15 to 71 per cent of women experience physical and/or sexual violence by an intimate partner at some point in their lives (WHO, 2010). There is some North American research (primarily from the U.S.) which indicates that men and women perpetrate domestic violence at approximately the same rate (WHO, 2010). Caution must be used in interpreting this statement, as it does not mean to suggest that the research indicates that men and women are victimized at approximately the same rate.

There is other evidence that suggests the violence experienced by male partners may be as a result of their female partners attempting to defend themselves (WHO, 2010). In addition to this, data indicates that compared with male victims of relationship violence, women are:

- Three times more likely to be injured;
- Five times more likely to require medical attention or hospitalization;
- Markedly more likely to suffer negative mental health impacts (VicHealth, 2007).

It is well documented that victimized girls and women often suffer:

- Adverse mental health conditions (e.g., depression and anxiety);
- Poor physical health consequences (e.g., chronic headaches and nausea);
- Behavioral problems that further damage their health (e.g., substance abuse, alcoholism and increased risk of suicide attempts) (Graffunder et al., 2004).

The negative effects of DV and SV for women cannot be ignored. In fact, VicHealth (Australia) concluded that DV and SV were larger risk factors for adverse health effects than raised blood pressure, tobacco use and increased body weight (VicHealth, 2007).
The costs of these negative health effects are substantial. In 2003, the Centers for Disease Control and Prevention (CDC) estimated that medical and other costs associated with DV against women exceeded $5.8 billion annually.

### 4.2 The Canadian Context

In researching rates of DV and SV in Canada, it was observed that most reference material relies on the data collected by Statistics Canada. Since the first attempt in 1999 by Statistics Canada to measure spousal violence in a comprehensive way on traditional victimization surveys, the general trend has seen rates declining over the past decade (Statistics Canada, 2009).

However, this is not to say that DV and SV are no longer of concern. In fact, Canadian statistics support the claim that DV and SV are still significant issues. In its 2009 report on Family Violence in Canada, Statistics Canada reported:

- Nearly 40,200 reported incidents of spousal abuse (2007 data). This represented approximately 12 per cent of all police-reported violence crime in Canada;
- For female victims, rates of spousal violence was highest among women aged 25-34;
- Spousal homicide rates were highest for persons in the 15-24 year-old age group;
- Female victims of domestic violence were nearly twice as likely to have been victimized by a spouse (as compared with men, who are more likely to be victimized by other family members) (Statistics Canada, 2009).

The majority of victims of spousal violence continue to be females, accounting for 83 per cent of victims. Compared to male victims of DV, women are five times more likely to report fearing for their lives (Statistics Canada, 2003). In fact, almost four times as many women were killed by a current or former spouse than men (Statistics Canada, 2009). Overall, Aboriginal women are at significantly higher risk of spousal violence and spousal homicide than non-Aboriginal women (Johnson, 2006).

#### 4.2.1 The Alberta Disadvantage

Over the past 15 years, Albertans have been fortunate to enjoy one of the best economies in the country. This strong economy has contributed to a high quality of life for many, and the phrase “The Alberta Advantage” was the province’s official motto.

However, there is a distinct disadvantage to Alberta seen in the area of spousal abuse. Between 1999 and 2004, Alberta was the province with the highest reported rate of spousal assaults in Canada (Government of Alberta, 2008). The 2009 General Social Survey shows rates for Alberta and Saskatchewan to be the highest in the country, at
eight per cent as compared to the rate for all Canadians—six per cent (Statistics Canada, 2011). Between 2000 and 2006, there were a total of 170 deaths from spousal abuse in Alberta, for an average of more than 20 such deaths per year over that period (Cairns & Hoffart, 2009). Currently, Alberta has the second highest rate of spousal violence in the country and leads the country in domestic assault, homicide-suicide and stalking (Calgary Women’s Emergency Shelter, 2009).

### 4.2.2 Calgary Context

In Calgary alone, statistics for 2010 show there were over 13,000 calls to police pertaining to domestic violence, with over 4,000 recorded domestic violence offenses (Calgary Police Service, 2010). In the same year, over 7,800 children were subject to or witness of a domestic incident (M. Boulanger, personal communication, December 15, 2011).

In a 2009 Family Violence Community Needs Assessment Survey (Calgary Women’s Emergency Shelter, 2009), 59 per cent of Calgarians reported that they feel family violence is more serious today than it was 10 years ago. In fact, 62 per cent of those surveyed reported that they have personally known someone who has experienced family violence.

**Points to Consider:**

1. **More evidence is needed at the local level:** There is some evidence of DV and SV rates for Canada, and even less for Alberta. A great deal more data is required in order to develop primary prevention strategies that address the issue, especially at the provincial and municipal level.

2. **More evidence is needed on who is perpetrating DV:** There is some evidence from the U.S. that suggests men and women perpetrate at approximately the same rate. Gathering evidence to support or refute this assertion at the local level is important as this information will support the development of appropriate primary prevention DV strategies.
5.0 Risk and Protective Factors

There is a lack of consensus whether the risk and protective factors of DV and SV are fully understood (Harvey et al., 2007). Regardless, most pieces of DV and SV literature include a section on risk and protective factors. These can be at the individual, relationship, community or societal level (Alaska Network on Domestic Violence & Sexual Assault, 2010).

A life-course perspective is often used in prevention strategies (WHO, 2010). This perspective is based on the idea that influences early in life can act as risk factors or protective factors for health-related behaviours at subsequent or later stages.

The WHO divides the life course into the following stages:
- Infancy (0-4 years)
- Childhood and early adolescence (5-14 years)
- Adolescence and young adulthood (15-25 years)
- Adulthood (26 years and over)

Risk factors for DV and SV can be defined as an attribute or exposure that increases the probability of the occurrence of DV or SV. These can exist for those at risk of perpetrating violence as well as those at risk of being a victim of violence. The first table lists individual risk factors for both perpetration of violence (by men) and victimization of violence (of women) that are common to both domestic violence and sexual violence.

Table 1: Individual risk factors for both DV and SV (WHO, 2010). Those factors that have the strongest reported effect (or consistently reported across studies) are indicated with an asterisk.

<table>
<thead>
<tr>
<th>Characteristics for Perpetration</th>
<th>Characteristics for Victimization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Demographics</td>
</tr>
<tr>
<td>- Low income</td>
<td>- Young age*</td>
</tr>
<tr>
<td>- Low education*</td>
<td>- Low education*</td>
</tr>
<tr>
<td>Exposure to child maltreatment</td>
<td>Exposure to child maltreatment</td>
</tr>
<tr>
<td>- Sexual abuse*</td>
<td>- Intra-parental violence*</td>
</tr>
<tr>
<td>- Intra-parental violence</td>
<td>Mental Disorder</td>
</tr>
<tr>
<td>Mental Disorder</td>
<td>- Depression</td>
</tr>
<tr>
<td>- Antisocial personality*</td>
<td></td>
</tr>
</tbody>
</table>
### Substance Use

- Harmful use of alcohol*
- Illicit drug use

### Acceptance of Violence*

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Acceptance of Violence</th>
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</thead>
<tbody>
<tr>
<td>Harmful use of alcohol*</td>
<td></td>
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<tr>
<td>Illicit drug use</td>
<td></td>
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</tbody>
</table>

### Relationship Level

<table>
<thead>
<tr>
<th>Multiple partners/infidelity</th>
<th>None listed</th>
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</thead>
<tbody>
<tr>
<td>Low resistance to peer pressure</td>
<td></td>
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</tbody>
</table>

### Community/Societal Level

<table>
<thead>
<tr>
<th>Weak community sanctions</th>
<th>Weak community sanctions</th>
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<tbody>
<tr>
<td>Poverty</td>
<td>Poverty</td>
</tr>
<tr>
<td>Traditional gender norms and societal norms supportive of violence</td>
<td>Traditional gender norms and societal norms supportive of violence</td>
</tr>
</tbody>
</table>

When looking solely at domestic violence, there are additional risk factors added to the list (Edleson, 2000; Moloughney, 2007; VicHealth, 2007, WHO, 2010). Again, most of those identified are at the individual level.

Table 2: Risk factors solely applicable for DV. Those factors that have the strongest reported effect (or consistently reported across studies) are indicated with an asterisk (WHO, 2010).

<table>
<thead>
<tr>
<th>Characteristics of Perpetration</th>
<th>Characteristics of Victimization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Level</strong></td>
<td><strong>Individual Level</strong></td>
</tr>
<tr>
<td>Demographics</td>
<td>Demographics</td>
</tr>
<tr>
<td>- Young age</td>
<td>- Gender (being a woman)</td>
</tr>
<tr>
<td>- Low socio-economic status</td>
<td>- Low socio-economic status</td>
</tr>
<tr>
<td>- Unemployment</td>
<td>- Pregnancy</td>
</tr>
<tr>
<td>Exposure to child maltreatment</td>
<td>Exposure to child maltreatment</td>
</tr>
<tr>
<td>- Sexual abuse*</td>
<td>- Sexual abuse*</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>- Low self-esteem</td>
<td>- Impulsivity</td>
</tr>
<tr>
<td>- Impulsivity</td>
<td>- Alcohol consumption and dependence</td>
</tr>
<tr>
<td>- Attachment style</td>
<td>- Low self-esteem</td>
</tr>
<tr>
<td>- Alcohol consumption and dependence</td>
<td>- Exposure to prior abuse/victimization*</td>
</tr>
<tr>
<td>Prior history of being abused*</td>
<td></td>
</tr>
</tbody>
</table>

When looking solely at domestic violence, there are additional risk factors added to the list (Edleson, 2000; Moloughney, 2007; VicHealth, 2007, WHO, 2010). Again, most of those identified are at the individual level.
The relationship between education and DV and SV is complex. While low levels of education is a consistent factor associated with both DV and SV perpetration and victimization, there are subtle nuances in how this plays out.

Women who report low levels of education have an increased risk of DV compared to higher-educated women. Men with lower education were more likely to perpetrate DV than those with higher levels of education. However, when women have higher educational levels than their partner, they may be at greater risk of DV (WHO, 2010). There is some speculation that men may use violence to gain power within a relationship when the woman’s level of education is higher. In addition, there is some research that suggests women with higher levels of educational attainment are at an increased risk of sexual intimate partner violence.

For women, higher education only acts as a protective factor when their partners have relatively the same level of education. In relationships where there are relatively equivalent levels of education, DV levels tend to be lower (WHO, 2010).
Finally, there are some other risk factors specific to risk of sexual violence perpetration/victimization.

Table 3: Additional risk factors of SV.

<table>
<thead>
<tr>
<th>Perpetration by Men</th>
<th>Victimization of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Level</td>
<td>Individual Level</td>
</tr>
<tr>
<td>Gang membership</td>
<td>Separated/divorced and single women</td>
</tr>
<tr>
<td></td>
<td>Early exposure to sexual activity</td>
</tr>
<tr>
<td></td>
<td>Prior victimization</td>
</tr>
<tr>
<td>Societal Level</td>
<td>Societal Level</td>
</tr>
<tr>
<td>Ideologies of male sexual entitlement</td>
<td>Ideologies of male sexual entitlement</td>
</tr>
<tr>
<td>Weak legal sanctions</td>
<td>Weak legal sanctions</td>
</tr>
</tbody>
</table>

Education may play a role in the risk of victimization of sexual violence, as research shows a relationship between lower female educational levels and experiences of SV (WHO, 2010).

The literature also reports additional risk factors for violence in general. These include:

- Absent and rejecting father (risk factor for perpetration) (Edleson, 2000)
- Being raised in a male dominant family (risk factor for perpetration) (Edleson, 2000)

Protective factors, or resilience factors, also play a role in influencing tendencies towards DV or SV. Generally, protective factors are those that influence the capacity of an individual to develop positively despite harmful environments and experiences (Edleson, 2000).

Some identified protective factors of DV and/or SV include:

- Formal marriage (Daigneault, Hebert, & McDuff, 2009)
- Over the age of 65 (Breiding, Black, & Ryan, 2008)
- Income (over $50,000 annually) (Breiding et al., 2008)
- Actively involved and connected to schools (Edleson, 2000)
- Belonging to an association (WHO, 2010)
- Living within an extended family (WHO, 2010)
- Positive academic achievement (Edleson, 2000)
- Strong links with supportive adults (Edleson, 2000)
• Being employed (Prevention Institute, 2006)
• Experiencing authoritative parenting (parental encouragement and support and non-coercive rule-setting and monitoring) (Edleson, 2000; WHO, 2010)

While there is some good information on the risk and protective factors for DV and SV, it is unclear how these factors interact with each other. For example, if a young woman is doing well academically, has a strong social network and is connected to her school, does this counteract the risk factors of living in poverty and being witness to domestic violence as a child? More research is needed in this area in order to develop effective primary prevention strategies at the individual level.

In addition, it is important to remember that some macro-level risk factors such as traditional gender and social norms can play out at the community, relationship and individual level.

Points to Consider:

1. **More research on protective factors is required**: If an asset-based model is to be considered (e.g., healthy relationships as a focus for primary prevention strategies), then more research on protective factors is necessary in order to create strategies that promote healthy relationships

2. **More research on how risk and protective factors interact is required**: There is a good foundation of information on risk factors. However, what is less understood is how risk and protective factors interact with each other. How many protective factors need to exist before the risk factors are diminished? Which protective factors act more strongly than any risk factor?
6.0 Approaches and Frameworks for Understanding

There have been many approaches and perspectives used to understand DV and SV over the course of the past 30 years. Some philosophies have traditionally been understood as a natural part of the conversation, such as the feminist perspective. Others, such as the public health approach, have only more recently been used to frame the issue of DV and SV.

6.1 Approaches

For the past three decades, the feminist approach has been used to frame the issue of DV and SV. This approach looks at the issue of patriarchy, power relations and constructions of masculinity and femininity as the primary drivers of the problem (WHO, 2010).

The Human Rights approach views DV and SV as violations of human rights in themselves, but recognizes that they also rob individuals of other human rights such as physical and mental health, security, equality in the family and equal protection of men and women under the law (Amnesty International, 2010). This approach sees the state as being obligated to respect, protect and fulfill human rights (WHO, 2010).

Within the human rights approach, the state is viewed as often failing to take the necessary actions to combat such forms of violence. Organizations such as Amnesty International and the Swedish International Development Cooperation Agency use a human rights framework to ground their gender-based violence strategies and action plans (Gender Secretariat, 2008). Most recently, the Council of Europe has adopted a human rights approach with *Convention on preventing and combating violence against women and domestic violence* (Amnesty International, 2010).

Another approach that has been used by governments and states is the criminal justice approach. The main focus here is on responding to DV and SV after it has occurred by enforcing laws (WHO, 2010). In regards to prevention, the criminal justice approach relies on deterrence, incarceration and punishment. Both the U.K. and New Zealand are more oriented to a criminal justice/crime prevention approach (Carmody, 2009).

Using a blended model, the medico-legal approach to DV and SV integrates both public health and criminal justice approaches. With this model, there is recognition that many sectors and disciplines are required to prevent violence and extend better care and safety to affected populations (Kearns, Coen, & Canavan, 2008). Elements of both approaches are blended in order to create a model that uses rigour in defining and addressing a population health concern while simultaneously attempting to deter
potentially violent behaviour at the individual level. The Child and Family Research Centre in Ireland describes the country’s national strategic policy on DV as a medico-legal approach (Kearns et al., 2008). In addition, it seems the Domestic Violence Prevention Committee in Nova Scotia, Canada, uses a medico-legal approach (Domestic Violence Prevention Committee, 2009). It recommends that the safety of victims be the most important consideration in any work moving forward, and that primary prevention strategies need to reflect a social determinant of health perspective.

At present, the public health approach to prevention is most commonly used by major organizations globally, such as the WHO and Centers for Disease Control and Prevention (Graffunder et al., 2004; VicHealth, 2007; WHO, 2010). This is a science-driven, population-based, interdisciplinary approach that seeks to provide the maximum benefit for the largest number of people while extending better care and safety to the entire population (WHO, 2010). This model is widely used, even if not specifically named (Carmody, 2009). The public health approach draws on knowledge from a range of disciplines such as medicine, sociology, psychology, epidemiology, criminology, education and economics, making it a robust model for addressing DV and SV (WHO, 2010). Additionally, it suggests that DV and SV are not the result of any single factor, but rather an outcome of multiple risk factors and causes, thereby necessitating a multi-sector approach.

What is common to all the above approaches is that they identify gender-based, discriminatory attitudes and unequal power structures as key drivers in the continuation of DV and SV. They assert that community attitudes and social norms are integral to the existence of DV and SV, and that addressing both of these is a key strategy for prevention (Carmody, 2009).

**Points to Consider:**

1. **Consideration of Alberta’s social context is required:** Deciding on which approach is to be used will require an analysis of the current social context in Alberta. In addition, what is good for cities is not always aligned with the broader provincial context. These contexts will need to be carefully analyzed in order to adopt an approach that is meaningful, but not polarizing, for urban and rural communities.

2. **Consider blending approaches:** The medico-legal approach is a good example of how to blend elements from two models in order to align to the context in which it is to be applied.
6.2 Frameworks

In the review of the literature, the two most prevalent frameworks used to address DV and SV are “the ecological framework” and the “Spectrum of Prevention.” Both frameworks emphasize the importance of a multi-layered approach, with strategies targeting individuals, communities and society. Both recognize that any approach to addressing DV and SV must be implemented across jurisdictions, by multiple departments and at various levels of society (Carmody, 2009).

6.2.1 The Ecological Model

The ecological model stems from the field of developmental psychology, suggesting that behaviour is shaped through individual and societal interactions (Edleson, 2000). The ecological model proposes that DV and SV are the result of interactions between factors at a range of levels (Carmody, 2009; Edleson, 2000; WHO, 2002).

These levels are:
- Individual—personal history and psychology
- Relationship—household dynamics and circumstances
- Community—physical and demographic features of an area in which people live
- Societal—cultural norms, structures and processes, laws and policies

There are many variations on the above model. Some jurisdictions have chosen to blend the individual and relationship so that only three levels are identified (VicHealth, 2007). Others have expanded on the four above, separating out policies and laws from cultural norms and beliefs (Edleson, 2000).
Primary prevention efforts must be present at all levels—hence the comprehensiveness of the model. The strength of such a model is that it provides multiple points of entry for prevention strategies (i.e., not just strategies aimed at the individual). For example, if there is evidence from psychological models about individual risk factors and from feminist models about societal risk factors, they can both be incorporated in the same ecological model (Centers for Disease Control and Prevention, 2004). Additionally, it expands the concepts of risk and protective factors by accounting for the role of larger political, social and cultural contexts as they related to social ills (Chamberland et al, 2000).

Many entities are using the ecological model as a framework for their DV and SV primary prevention efforts. Both the Centers for Disease Control and Prevention (CDC)—Division of Violence Prevention (DVP) and VicHealth—State Government of Victoria (Australia) will be explored in greater detail as two examples of the ecological model.

**Example 1: Centers for Disease Control and Prevention—The DELTA Program**

The Centers for Disease Control and Prevention (CDC) provide funding, networking opportunities, training and technical assistance to support primary prevention of DV and SV (Centers for Disease Control and Prevention, 2009).

The Family Violence Prevention Services Act (FVPSA) authorizes CDC to distribute funds to support co-ordinated community responses (CCRs) that address domestic violence and sexual violence. A CCR is an organized effort among many partners, such as law enforcement, public health and victim services, to prevent and respond to DV and SV in a community (Centers for Disease Control and Prevention, 2009). In 2002, CDC used FVPSA funding to develop the Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) Program where the focus is the primary prevention of DV and SV at the community level. Through this program, the CDC funds 14 state-level domestic violence coalitions to provide prevention-focused training, technical assistance and financial support to local co-ordinated community responses. The coalitions are made up of non-profit organizations, which then use program funding to represent and support the work of local DV programs. Enhanced capacity is necessary so that multi-level change strategies can be implemented, while taking into account the unique needs and cultures of their respective communities.

**Example 2: Alaska—Pathways to Preventing Domestic Violence**

There are many examples within the 14 DELTA-funded state coalitions of primary prevention strategies. Funded coalitions include Alaska, California, Delaware, Florida, Kansas, Michigan, Montana, New York, North Carolina, North Dakota, Ohio, Rhode Island, Virginia and Wisconsin (Graffunder et al, 2004).
Alaska has recently completed its comprehensive plan for preventing violence. The plan, entitled “Pathways to Preventing Domestic Violence in Alaska,” was completed in March 2010. This plan establishes a framework for organizing and co-ordinating a range of prevention and promotion efforts over the next six years (Alaska Network for Domestic Violence and Sexual Assault, 2010).

The plan was many years in the making, with efforts starting shortly after receiving DELTA funding in 2003. Between 2005 and 2008, the Pathways Statewide Steering Committee undertook a statewide needs and resource assessment specific to domestic violence prevention. Information gathered informed the direction of the plan. Between 2007 and 2009, the committee brought together all available information on the prevalence of domestic violence, risk and protective factors for perpetration and victimization, along with the assessment of existing prevention efforts. The resulting framework specifies seven goals, or pathways, for ending domestic and teen-dating violence in Alaska:

1. Establish statewide infrastructure to co-ordinate domestic violence, teen dating and sexual violence prevention efforts;
2. Ensure that data on the prevalence and the prevention of domestic violence are standardized and easily accessed across systems in Alaska;
3. Ensure teen dating and domestic violence prevention curricula are integrated into public school grades K-12;
4. Develop youth as leaders in primary prevention efforts;
5. Ensure statewide partners support program development and approaches that promote parity across class, race, gender and religion, thereby addressing the root causes of violence;
6. Create partnerships with media sources in promoting respect, healthy relationships and equality;
7. Engage Alaskan communities in promoting healthy relationships.

Within each of these seven goals are more specific strategies that support achievement of the overarching goal, preventing violence before it ever starts. Alaska is provided as an example for two reasons: (1) of the reviewed primary prevention frameworks, it was the only one which provided a definition of healthy relationships and (2) Alaska selected the evidence-based and Canadian-developed Fourth R Program in order to reduce

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4 The 4th R is a Canadian-based comprehensive school program aimed at reducing three interconnected risk behaviours in adolescents; violence, substance abuse and unsafe sex. It applies a youth-focused, harm reduction strategy aimed at Grade 9 students. The program itself is a 21-lesson curriculum provided through Health and Physical Education classes. See Crooks, Wolfe, Hughes, Jaffe, & Chiodo, 2008.
violence and promote related protective factors to prevent perpetration and victimization. The program was adapted for implementation in communities across Alaska (Alaska Network for Domestic Violence and Sexual Assault, 2010). This will be a program to watch, as an evaluation will be undertaken and results available over the next several years.

**Example 3: State Government of Victoria—VicHealth**

In December 2007, the State Government of Victoria—VicHealth released its background paper and framework for the primary prevention of violence against women in Victoria, Australia. The report was commissioned by the Victorian Government in 2006, and was designed to review international evidence regarding the factors causing violence against women and the good practice models to prevent it (VicHealth, 2007). An evidence-based framework was then developed to support further efforts in preventing violence against women.

In 2003, VicHealth identified violence against women as a priority within its broader mandate of addressing preventable causes of poor mental health, given the strong evidence for the link between this form of violence and anxiety, depression and other mental health problems (VicHealth, 2004). In 2006, the Family Violence Interdepartmental Committee (in consultation with others), undertook to support the development of a whole-of-government plan to guide activity in the primary prevention of violence against women (VicHealth, 2007). The need for sound and informed policy, co-ordinated action amongst many stakeholders and appropriate resource allocation was recognized. VicHealth supported the planning process and the development of a conceptual framework to guide primary prevention of violence against women, as documented in the released paper.

VicHealth (2007) uses an ecological framework to understand violence against women (within this model, a program logic approach is taken to develop six layers of possible action). In the first two layers, broad themes for action are identified (e.g., promoting equal and respectful relationships between men and women and promoting non-violent norms). In the third and fourth layers, seven general strategies are provided to guide action (e.g., advocacy, research and evaluation, direct participation programs) and the particular groups that these strategies should be targeted at and/or tailored for. Finally, the fifth and six layers identify a range of conditions at the individual, organizational, community and societal levels that can be built and monitored.

Overall, the plan provides a series of recommendations for planning as well as steps for future direction. The framework also provides information on potential populations of focus, such as Indigenous populations or those living in rural communities. In Victoria, there is a strong government policy platform, as well as emerging commitment from the
corporate and non-government sectors to take responsibility for contributing to the development of safe environments for women.

### 6.2.2 Spectrum of Prevention

Similar to the ecological model is the Spectrum of Prevention. Originally developed in the treatment of developmental disabilities, it has been used in prevention initiatives targeting traffic safety, injury prevention and violence prevention (Prevention Institute, 1999).

The Spectrum of Prevention is a systematic tool which supports the conceptualization and implementation of comprehensive primary prevention strategies. It is a six-level tool that can assist in the advancement of a community solution to DV and SV and helps people move beyond the perception that prevention is merely education (Prevention Institute, 2006). At its essence is the belief that a single individual or sector cannot address the problem alone (National Sexual Violence Resource Center, 2006).

Table 4: Six levels of the Spectrum (Prevention Institute, 2007).

<table>
<thead>
<tr>
<th>Levels of the Spectrum</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening individual knowledge and skills</td>
<td>Enhancing an individual’s capability of preventing injury or crime</td>
</tr>
<tr>
<td>Promoting community education</td>
<td>Reaching groups of people with information and resources in order to promote health and safety</td>
</tr>
<tr>
<td>Educating providers</td>
<td>Informing providers who will transmit skills and knowledge in others</td>
</tr>
<tr>
<td>Fostering coalitions and networks</td>
<td>Bringing together groups and individuals for broader goals and greater impact</td>
</tr>
<tr>
<td>Changing organizational practices</td>
<td>Adopting regulations and norms to improve health and safety; creating new models</td>
</tr>
<tr>
<td>Influencing policy and legislation</td>
<td>Developing strategies to change laws and policies in order to influence outcomes in health, education and justice</td>
</tr>
</tbody>
</table>

Essentially, the Spectrum of Prevention is a tool which emphasizes the inter-relatedness between levels, thereby maximizing the results of each activity and creating a more transformative force (Prevention Institute, 2007). This enables advocates and practitioners to maximize the result of any one prevention activity (Prevention Institute, 2006).
This model of primary prevention is being used by the Prevention Institute (2006, 2007) and The National Sexual Violence Resource Centre (2006). These two cases will be explored as examples of the Spectrum of Prevention.

**The Prevention Institute**

Founded in 1997, the Prevention Institute is a non-profit, national centre dedicated to “improving community health and well-being by building momentum for effective primary prevention” (Prevention Institute, 2007, p 5). The institute has a strong commitment to community participation and promotion of equitable health outcomes for all social and economic groups. The organization focuses on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity and youth development.

In 2007, the Prevention Institute published a document entitled “Poised for Prevention: Advancing Promising Approaches to Primary Prevention of Domestic Violence.” The impetus for this document was the gathering of a group of DV leaders in the United States. This diverse set of local and national leaders pressed for an immediate and coherent approach to primary prevention of DV that would build on the many successes already achieved.

According to the Prevention Institute, addressing the role of norms is a central starting point for addressing DV and SV. They assert that substantial reductions in DV and SV are more likely to be achieved when environmental influences are consistent with prevention efforts (Prevention Institute, 2007). As environments are powerful in influencing behaviour, it is critical to understand and address norms.

Guiding principles for the primary prevention of DV as identified by the Prevention Institute are:

- Focus on changing norms to change behaviour
- Foster comprehensive and integrated systems for prevention
- Engage community leadership and be responsive to community strengths and needs
- Invite, don’t indict, men as stakeholders in prevention
- Emphasize the role of bystanders in prevention
- Start early/young
- Focus on assets along with risk factors
- Build on existing assets and efforts

The document stresses that the emphasis needs to be on promoting a positive set of behaviours through the creation of environments and norms that promote and support these behaviours. The Institute lists strategies for this across the six Spectrum of
Prevention layers. Of note are strategies within “Foster Coalitions and Networks,” as they stress the need to engage diverse community and systems’ leaders as key partners in the strategy for prevention. They emphasize that engaging men as leaders, especially those outside the field of DV and SV, is critical at this juncture—just women speaking to women and advocates speaking to advocates is not sufficient to create the critical mass necessary to change social norms (Prevention Institute, 2007).

National Sexual Violence Resource Center

The National Sexual Violence Resource Center (NSVRC) in the U.S. was developed as the principle information and resource centre regarding all aspects of SV. It collects and disseminates a wide range of resources on SV, including statistics, research, statutes, training curricula, prevention initiatives and program information (Davis, Fujie Parks, & Cohen, 2006). It provides national leadership within the United States and has become critical in providing technical assistance and professional consultation to SV prevention programs and allied individuals.

In 2006, the NSVRC commissioned the report: “Sexual Violence and the Spectrum of Prevention: Towards a Community Solution” in order to outline a primary prevention approach to addressing sexual violence. The document provides examples of programs and interventions targeted at each level of the spectrum. For example, in the second level of “Promoting Community Education,” the document provides information on a number of activities that enhance sexual violence information and resources for members of the community. Again, the importance of changing norms is central throughout the activities listed within the six-layer spectrum.

6.2.3 Evaluating the Models

The models presented are the two used throughout the literature reviewed. While the ecological approach is used more frequently in the literature, the Spectrum of Prevention has been in existence for more than 30 years and has been used in many large-scale prevention efforts.

Both models are comprehensive and frame primary prevention efforts outside the context of individual strategies. Both models also identify potential areas for primary prevention activities, and emphasize the critical nature of data and evaluation. Either one of these frameworks could serve as a foundational base for the development of a comprehensive primary prevention strategy for DV and SV.

While the two models share many similarities, there are some slight differences worth mentioning. While both models emphasize the importance of data and evaluation, the
Spectrum of Prevention stresses that the experience and wisdom of survivors, advocates, educators and practitioners as key data sources needs to be honoured in the development of prevention strategies (Davis, Fujie Parks, & Cohen, 2006). It emphasizes that as an initiative is shaped, it is essential to identify ways of measuring and gathering input from participants and the community. In fact, it stresses the necessity of communities in violence prevention strategies and acknowledges that local initiatives can better respond to the needs of a specific community.

In framing prevention strategies, the Spectrum of Prevention uses “norms” as the starting point of prevention activities while the ecological model uses “known risk and protective factors” as the starting point. This is a subtle difference, but one that is important to note as it has implications for framing any subsequent strategy.

**Points to Consider**

1. **Ensure multiple points of prevention are addressed:** Regardless of which framework is utilized, having prevention efforts at individual, organizational, policy and systems levels are essential.

2. **Community participation is critical:** The Spectrum of Prevention appears to be more aligned with participatory approaches and community building. If an ecological framework is chosen, consider employing participatory approaches and principles for implementation.

3. **Norms play an important part of DV and SV prevention:** Regardless of which framework is applied, the importance of norms in the proliferation of DV and SV cannot be understated. Norms must play a central role in any primary prevention framework.

4. **Consider a blend of frameworks:** There are strengths in both frameworks. Using the ecological model’s emphasis on risk factors as the starting points for strategies, combined with the Spectrum’s emphasis on education, resources and community capacity building would allow for a greater flexibility in design.
7.0 Promising Practices for DV and SV Prevention

A fundamental question to ask when developing a primary prevention framework is “do domestic and sexual violence prevention programs work”?

The literature provides a clear answer—little is known about effective primary prevention strategies. There are several reasons for this, such as the relative newness of focus on primary prevention for DV and SV, incomplete information on risk factors and associated causal pathways, and the lack of adequately evaluated programs and interventions (Moloughney, 2007). Currently, the overwhelming majority of data is from the United States (WHO, 2010). The positive side of the lack of evidence in all countries is the fact that the generating of evidence and well-designed outcome evaluation procedures are top priorities everywhere.

7.1 Effective Programs and Interventions

Most of what has been evaluated has been those programs and interventions targeting proximal risk factors—primarily at the individual and relationship levels (of the ecological model). Generally, primary prevention strategies are intended to introduce new values, thinking processes and relationship skills to particular population groups that are incompatible with violence and promote the concept of healthy non-violent relationships (Jaffe & Wolfe, 2003).

What makes a program effective? The World Health Organization (2010) asserts that effectiveness can only be demonstrated by using rigorous research designs, most often in the form of a randomized-control trial or quasi-experimental design. Anything less, such as qualitative approaches, is considered interesting but not helpful in determining the effectiveness of a program.

Generally, evidence-based programs are those that are well-defined and have demonstrated their efficacy through rigorous, peer-reviewed evaluations and have been endorsed by government agencies and well-respected research organizations (Small, Cooney, & O’Connor, 2009). This differs from evidence-based practise, which is generally understood to be the integration of the best available research evidence with clinical expertise and client values. They tend to be practices used with individual clients as opposed to being components of the larger program.

Evidence-based programs demonstrate a number of components that are essential for achieving positive impacts (Small et al., 2009). These include:
• **Program design and content**: Must be theory driven, of sufficient dosage and intensity, comprehensive and actively engaging;
• **Program relevance**: Should be developmentally appropriate, timed appropriately and socio-culturally relevant;
• **Program implementation**: Must be delivered by well-trained and qualified staff, and should focus on fostering a good relationship;
• **Program assessment and quality assurance**: Needs to be well-documented and committed to evaluation and refinement.

Of the sparse evidence available, there is even less that focuses on successful strategies that are not programmatic in nature. Comprehensive community strategies are designed to affect social change by creating an enabling environment for changing individual attitudes and behaviour (Harvey et al., 2007). Community mobilization emphasizes the role of individuals as agents of change, rather than as passive program recipients. The priority here is on community ownership and leadership of the change process.

In the review of the literature, there are many different avenues for targeting prevention activities (e.g., education, mass media/communications and marketing, workplaces). By far, the two most popular areas of focus have been education and public/community awareness programs, although there have been other avenues targeted.

### 7.2 Home Visitation Programs

There is no doubt that childhood physical abuse, sexual abuse or growing up witnessing abuse is a significant risk factor for future perpetration or victimization of domestic violence in adulthood (Whitfield, Anda, Dube, & Felitti, 2003; WHO, 2010). Research does show that evidence-based home visitation programs have proven effective in preventing and reducing child abuse, and new research is showing that they can also prevent and reduce domestic violence (McLennan, MacMillan, & Jamieson, 2004; Nurse Family Partnership, 2011). Home visitation programming has been used to improve child development outcomes, and is most often used with high-risk families with children between ages 0-3 years (Cooper, 2009). Generally, home visitation refers to comprehensive, stand-alone programs or to occasional, semi-structured visits to the homes of program participants to supplement other programming. Home visitation programs offer one-on-one support directly to the family via visits from a professional (such as a nurse or social worker), paraprofessional or lay visitor on the well-founded assumption that improvements in parenting and home life will contribute to better health and developmental outcomes for children (Cooper, 2009).
One of the best examples is the Nurse-Family Partnership (NFP) program, which has been tested through multiple randomized controlled trials (Olds et al., 2011). Based on the long-term success of the NFP, research is now showing that enhanced violence-prevention programs based on the NFP model, such as the Enhanced NFP and the Domestic Violence Enhanced Visitation Intervention (DOVE) are effective in preventing and reducing domestic violence as well as child abuse (Family Violence Prevention Foundation, 2010).

According to the Pew Center on the States (2010), home visitation programs are considered evidence-based when:

- They employ professional staff such as nurses or social workers;
- Are associated with a national organization or institution of higher education that has comprehensive home visitation standards that ensure high quality service delivery and continuous program quality improvement;
- Demonstrate fidelity to a home visitation model that:
  - Has been in existence for at least three years;
  - Has been evaluated using a well-designed and rigorous randomized controlled trial (RCT) and the evaluation results have been published in a peer-reviewed journal;
  - For which one or more RCT evaluations have sustained positive child abuse and domestic violence outcomes.

Caution should be used in regards to home visitation programming, however, as positive results of the NFP are often used to justify a variety of other home visitation programming that may or may not be evidence-based (Cooper, 2009). This is akin to suggesting that “if one antibiotic is shown to be effective, another type within a related class can be assumed to work—regardless of duration, dosage or underlying mechanism” (McLennan et al., 2004, p. 1070).

7.3 Education-Based Programs

There are a variety of education type prevention programs, depending on the population being targeted. These programs target conflict resolution and interpersonal skills (Smithey & Straus, 2003). Workshops, conferences and guest-lecturers are all included in the general sphere of education-based primary prevention type programming.

School-based anti-violence/respectful relationship programs are particularly popular and valuable, as they:
• Generally have the strongest evidence of effectiveness;
• Target a population at the stage of the life cycle when the risk of perpetration or victimization is high;
• Are part of the daily routines of most young people, enabling such programs to be delivered in a context in which the promotion of respectful, non-violence relationships can be normalized (VicHealth, 2007).

It is widely acknowledged that schools are an ideal place in which to introduce primary prevention programming. This allows for a wide range of children to be included and offers a stable environment for instruction (Jaffe & Wolfe, 2003). The programming itself can range from long-term, intensive programs which are integrated into formal curriculum, to single-session activities (Harvey et al., 2007). School-based programming can be broken down as targeting either elementary-aged children or adolescents and young adults.

School-based prevention programming that targets elementary-aged children introduces the discussion of personal safety and injury prevention, and integrates this discussion within the context of trusting relationships (Jaffe & Wolfe, 2003). The focus of these programs has mainly been on preventing child sexual abuse and increasing children’s capacity to protect themselves. It is important that with this age group, a high level of trust is encouraged so that children can disclose exposure to DV and SV and so that teachers can make appropriate referrals. Additionally, teaching appropriate social skills like conflict resolution as alternatives to violence is critical.

One example of such a program was implemented by the Minnesota Coalition for Battered Women, and was focused around the themes of “hands are not for hitting” and promoting students’ choice in alternatives to violence. In Canada, another example of such a program is Feeling Yes/Feeling No (Foon, 2010). Whether these programs are leading to actual reductions in victimizations has yet to be answered.

Early and mid-adolescence offers a critical window of opportunity for prevention efforts. Here, the focus is on creating awareness within teens of how violence in relationships can occur and on teaching healthy ways of forming intimate relationships (Jaffe & Wolfe, 2003). Late adolescence and the early adult years offer another critical juncture where prevention efforts are critical. Research has shown that violence within intimate partner relationships is not relegated to adulthood, but rather a common feature of adolescent dating relationships. Evidence of the high risk faced by college students can be seen in the proliferation of rape prevention programs (Harvey et al., 2007). Safe Dates is a well-researched and evaluated violence prevention program that has demonstrated reduction in psychological, moderate physical and sexual dating violence perpetration at four follow-up periods (WHO, 2010).
7.4 Public/Community Awareness Initiatives

Public awareness campaigns are the most common approaches to primary prevention of DV and SV with adults (Jaffe & Wolfe, 2003). These types of initiatives have been used globally to break the silence that surrounds these forms of violence and to change attitudes and social norms about its acceptability (Harvey et al., 2007). Generally, a human rights framework has been used in this type of prevention activity. While used widely, the link between such campaigns and behaviour change is not at all well established.

What is known is that these campaigns need to be grounded in evidence of the problem and relevant risk and protective factors; to define clear and measurable objectives; to include appropriate selection of the intended audience; and to use good consumer research that helps identify messaging, sources and materials to reach the intended audience.

Related to public awareness campaigns are social marketing campaigns (Harvey et al., 2007). They seek to develop persuasive messages by understanding the behaviour of the intended audience and involving them in program development, rather than simply disseminating information. This type of campaign has been used more frequently to address men’s social norms and behaviours, especially in relation to DV and SV.

Evaluation of an intensive six-month media broadcast that incorporated the theme of DV (plus print materials, a helpline and advocacy campaign) in South Africa showed the campaign had a positive impact on changing social norms and on dispelling beliefs that domestic violence is a private matter.

7.5 Comprehensive Community-Based Prevention Initiatives

Community level activism has been essential in raising the visibility of DV and SV as serious community issues that need to be addressed (Harvey et al., 2007). There are many different types of primary prevention activities that use a community approach. Community mobilization and community development approaches have been identified as potential avenues, and while very few have been evaluated for impact, investigations into their viability and acceptability to community yield promising results (VicHealth, 2007).

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5 National surveys were done before and after the intervention, as well as focus groups and in-depth interviews with target audience member and stakeholders at various levels.
6 http://www.soulcity.org.ca
Embedded within these types of initiatives are empowerment and participatory approaches. Essentially, these kinds of prevention activities have the potential to:

- Increase the collective efficacy of communities to take action in response to violence;
- Harness local leadership and resources to build protective social norms;
- Be tailored to the needs of specific communities, a specific consideration in addressing violence in communities requiring targeted approaches e.g., Aboriginal communities.

Raising Voices, an organization that engages in community mobilization, uses six key principles to inform and structure the community mobilization process:

1. Working with the whole community;
2. Encouraging both individuals and the whole community to embark on a process of change;
3. Using multiple strategies over time to build a critical mass of individuals supportive of women’s rights;
4. Supporting people to face the fact that violence isn’t something “out there;”
5. Inspiring and creating activism among a cross-section of community members.

Additionally, Raising Voices recognized that creating societal change requires moving outside of individuals. Hence, they modified the Stages of Change model used by public health researchers to Phases of Community Mobilization to structure the process of community engagement and mobilization (Michau, 2007).

### 7.6 Other Primary Prevention Practices

While the three areas of practice mentioned above contain quite a bit of literature, some systematic reviews include areas such as workplace programs, changes to the criminal justice system, and alcohol and substance misuse programs and initiatives. Interestingly, in regards to strategies that target alcohol and substance misuse there is some evidence that indicates it is an important component of violence prevention (Harvey et al., 2007).

### Points to Consider:

1. **Seize opportunities to contribute to the evidence-base of primary prevention strategies for DV and SV**: The literature quite clearly asserts that there is a lack of evidence for the effectiveness of primary prevention strategies. This presents a huge opportunity to add to this body of knowledge, with the potential of making Alberta a leader in this regard.
2. **Education programming needs to span developmental periods:** It is not sufficient to target education programs only at high-school or university students. Rather, there are programs that have been implemented at earlier age points (e.g., middle school or late elementary). This type of approach allows for greater impact.

3. **Consider social context when developing public awareness initiatives:** This is the most frequently documented way of changing social norms related to DV and SV. However, consideration of Calgary’s social context is required in order to create messaging that is truly impactful.

4. **Use rigour when using community development and mobilization as a primary prevention strategy:** While these approaches have been used, very few have been evaluated for impact. Again, this presents an opportunity to significantly contribute to the knowledge base in this area by engaging in rigorous evaluation appropriate to community development and mobilization strategies.
8.0 Conclusion

There is a wealth of information pointing to the desire of communities, cities and countries to prevent domestic violence and sexual violence from ever occurring. Across the U.S., 14 states have developed local coalitions to support, train and resource organizations to engage in primary prevention activities. Globally, many countries have dedicated time and energy to the creation of DV and SV primary prevention frameworks. International organizations, such as Amnesty International, UNIFEM (United National Development Fund for Women) and WHO have all stressed the importance of these issues and recommend the development of primary prevention activities.

While Canada contributes to the body of knowledge in the area of DV and SV through the high quality of its research\(^7,8\), there is an absence of any comprehensive primary prevention strategy that tackles these issues.\(^9\) Locally, there is an imperative to address DV and SV. With the second highest rate of spousal violence in the Canada, Alberta is poised for the development of a primary prevention framework. Calgary itself is well positioned to take the lead on the development and implementation of such a framework for a number of reasons, such as: strong research knowledge and capacity through the RESOLVE network and the presence of nationally recognized researchers in this area; resources dedicated to such an initiative (The Brenda Strafford Chair in the Prevention of Domestic Violence); and a community readiness to promote prevention.

The development of a primary prevention framework for DV and SV requires thoughtfulness and mindfulness, not only to the local context but to the efforts of others globally. What does this mean for Alberta? Essentially, this requires:

8.1 Adoption of a framework that fits the social context and philosophies of the local community

While a public health approach has been used in many jurisdictions to guide DV and SV prevention work, it needs to be determined whether it is the most appropriate for Alberta.

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\(^7\) RESOLVE is a tri-prairie research network that co-ordinates and supports research aimed at ending violence, especially violence involving girls and women. For more information see their website at http://www.ucalgary.ca/resolve/

\(^8\) Centre for Research & Education for Violence Against Women and Children promotes the development of community-centred, action research on violence against women and children. For more information, see their website at http://www.crvawc.ca/index.htm

\(^9\) Family Violence Initiative through the Public Health Agency of Canada (2009) is a secondary and tertiary response, seeking to reduce the occurrence of family violence.
8.2 Ensure that any framework considers the range of populations groups as well as the primary prevention actions required

In reviewing the primary prevention frameworks, several made specific efforts to address a range of population groups, such as:

- **Women and girls** (Gender Secretariat, 2008; VicHealth, 2007; WHO, 2010)
- **Men and boys** (Alaska Network on Domestic Violence and Sexual Assault, 2010; VicHealth, 2007)
- **Indigenous communities** (Alaska Network on Domestic Violence and Sexual Assault, 2010; VicHealth, 2007)
- **Culturally and linguistically diverse communities (including refugees)** (Gender Secretariat, 2008; VicHealth, 2007; WHO, 2010)
- **Women and girls with disabilities** (VicHealth, 2007)

Any developed framework also needs to employ a comprehensive suite of primary prevention methodologies. They are:

- **Direct participation programs** (Alaska Network on Domestic Violence and Sexual Assault, 2010; National Office for the Prevention of Domestic, Sexual and Gender-Based Violence, 2010; Centers for Disease Control and Prevention, 2010; VicHealth, 2007; WHO, 2010);
- **Organizational and workforce development** (Alaska Network on Domestic Violence and Sexual Assault, 2010; Centers for Disease Control and Prevention, 2010; National Office for the Prevention of Domestic, Sexual and Gender-Based Violence, 2010; Gender Secretariat, 2008; VicHealth, 2007; WHO, 2010);
- **Community strengthening** (Alaska Network on Domestic Violence and Sexual Assault, 2010; Centers for Disease Control and Prevention, 2010; VicHealth, 2007; WHO, 2010);
- **Communications and marketing** (Alaska Network on Domestic Violence and Sexual Assault, 2010; Centers for Disease Control and Prevention, 2010; National Office for the Prevention of Domestic,
Sexual and Gender-Based Violence, 2010; Gender Secretariat, 2008; VicHealth, 2007; WHO, 2010);

- **Advocacy** (National Office for the Prevention of Domestic, Sexual and Gender-Based Violence, 2010; VicHealth, 2007)

- **Legislative and policy reform** (Alaska Network on Domestic Violence and Sexual Assault, 2010; Centers for Disease Control and Prevention, 2010; National Office for the Prevention of Domestic, Sexual and Gender-Based Violence, 2010; Gender Secretariat, 2008; VicHealth, 2007; WHO, 2010);


### 8.3 Ensure any developed framework incorporates an Aboriginal and diversity perspective

A good example of this is reflected in the VicHealth model discussed.

### 8.4 Contribute to the body of knowledge in this area

A significant opportunity exists to contribute to the effectiveness of primary prevention programs and strategies through evaluation of programs and initiatives.

### 8.5 Learn from other initiatives

Alaska has developed its own primary prevention framework, along with Virginia and Australia. Keeping informed of their successes and challenges in this work will help inform Alberta’s journey.

While this document provides a starting point to understanding primary prevention strategies and frameworks, there now exists an opportunity to build upon this foundation to create a deep and solid structure for Alberta’s primary prevention framework to address domestic violence.
9.0 References


SHIFT TO STOP VIOLENCE BEFORE IT STARTS

Initiated by The Brenda Strafford Chair in the Prevention of Domestic Violence