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Lessons Learned in Evaluating a Multisite, Comprehensive Teen Dating Violence Prevention Strategy: Design and Challenges of the Evaluation of Dating Matters: Strategies to Promote Healthy Teen Relationships

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Abstract

Objective—This paper describes the multisite, longitudinal cluster randomized controlled trial (RCT) design of the evaluation of the Dating Matters: Strategies to Promote Healthy Relationships initiative, and discusses challenges faced in conducting this evaluation.

Method—Health departments in 4 communities are partnering with middle schools in high-risk, urban communities to implement 2 models of teen dating violence (TDV) prevention over 4 years. Schools were randomized to receive either the Dating Matters comprehensive strategy or the "standard of care" strategy (an existing, evidence-based TDV prevention curriculum). Our design permits comparison of the relative effectiveness of the comprehensive and standard of care strategies. Multiple cohorts of students from 46 middle schools are surveyed in middle school and high school, and parents and educators from participating schools are also surveyed.

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Results—Challenges discussed in conducting a multisite RCT include site variability, separation of implementation and evaluation responsibilities, school retention, parent engagement in research activities, and working within the context of high-risk urban schools and communities. We discuss the strengths and weaknesses of our approaches to these challenges in the hopes of informing future research.

Conclusions—Despite multiple challenges, the design of the Dating Matters evaluation remains strong. We hope this paper provides researchers who are conducting complex evaluations of behavioral interventions with thoughtful discussion of the challenges we have faced and potential solutions to such challenges.

Keywords

multisite randomized controlled trials; prevention; teen dating violence

Conducting multisite evaluations of behavioral interventions has unique challenges when compared with evaluations of a single intervention in a single location (Straw & Herrell, 2002), and some of these challenges have been encountered in attempts to conduct multisite evaluations of behavioral interventions to prevent violence (Henry, Farrell, & Multisite Violence Prevention Project Team, 2004). The purpose of this paper is to describe the research design of the effectiveness evaluation of the Center for Disease Control and Prevention's (CDC) comprehensive teen dating violence (TDV) prevention initiative, Dating Matters: Strategies to Promote Healthy Teen Relationships,[1] and to discuss the challenges faced in evaluating this initiative with a multisite, randomized controlled trial (RCT).

The Dating Matters: Strategies to Promote Healthy Teen Relationships Initiative

Research suggests adolescents living in high-risk (defined here as above average rates of crime and economic disadvantage) urban communities may be at elevated risk for experiencing and perpetrating TDV (Black et al., 2014; Niolon et al., 2015; Reed et al., 2014; Reed, Silverman, Raj, Decker, & Miller, 2011; Walton et al., 2009; West & Rose, 2000). However, relatively few etiological studies on TDV and few evaluations of TDV prevention initiatives have been conducted within this population (Fellmeth, Heffernan, Nurse, Habibula, & Sethi, 2013). Further, although the number of effective TDV prevention programs is growing (Foshee et al., 1998; Miller et al., 2012; Wolfe et al., 2009), few target TDV prevention at multiple levels of the social ecology in a truly comprehensive approach. However, in other areas of violence prevention, comprehensive strategies have been found to be more effective and have greater impact than single-strategy approaches to prevention (David-Ferdon & Simon, 2014). To address these gaps in the prevention of TDV, in 2011 CDC launched Dating Matters: Strategies to Promote Healthy Teen Relationships (Dating Matters), a comprehensive TDV prevention initiative (Tharp et al., 2011; Tharp, 2012). A primary objective of this initiative is to develop, implement, and evaluate the effectiveness of a comprehensive strategy intended to promote healthy relationship behaviors and decrease

[1]Dating Matters is a registered trademark of the Centers for Disease Control and Prevention.

TDV in high-risk urban communities. The comprehensive approach developed and implemented as part of Dating Matters is composed of both evidence-based and evidence-informed strategies and targets primary prevention of TDV at the individual, family, school, and community level. Given that a comprehensive approach to prevention of TDV has not yet been attempted or tested, and that many of the components of our comprehensive approach are yet untested, rigorous evaluation is critical in understanding the initiative's effectiveness. This paper briefly describes the outcome evaluation design of Dating Matters and discusses challenges and considerations for conducting a rigorous, multisite evaluation of a multicomponent intervention in high-risk urban communities.

Evaluation Design

The Dating Matters evaluation is a multisite, longitudinal cluster randomized controlled trial (RCT) comparing the Dating Matters comprehensive approach to the "standard of care" (hereafter referred to as "standard") approach (see Table 1 for a brief outline of each condition; the comprehensive approach is described in greater detail in Tharp et al., 2011). The standard comparison condition was chosen over a no-treatment-control condition, because at the time Dating Matters was developed, two TDV prevention programs had been rigorously tested and established as effective, although they had not yet been tested in high-risk urban communities (Foshee et al., 1998; Wolfe et al., 2009). Thus, this relative effectiveness approach compares the impact of the new comprehensive approach to an evidence-based program that is already available to communities and is already widely disseminated within the U.S, rather than comparing it with a no-treatment control group. Although this poses a greater challenge to the evaluation in establishing effectiveness, it is a reasonable approach to evaluation from a practical standpoint, given that evidence-based programs are already available. Safe Dates (Foshee et al., 1998) was chosen to serve as the standard approach (delivered to 8th graders in standard schools) and as a component of the comprehensive condition (it served as the 8th grade curriculum and as a foundation for developing the 6th and 7th grade curricula). Although effect sizes are modest, Safe Dates is the only evidence-based program demonstrating both short-term and long-term sustained (at 4-year follow-up) effects on the primary and secondary prevention of perpetration and victimization of multiple forms of TDV among both boys and girls, and is the most widely implemented TDV program in the United States (Foshee et al., 2004).

The effectiveness evaluation represents a collaboration among several entities: CDC designed and leads the cross-site evaluation, NORC at the University of Chicago implements the evaluation plan, including data collection, and four local health departments implement the comprehensive and standard approaches. These four local health departments, herein referred to as the Dating Matters "sites," are located in Alameda County, CA; Baltimore, MD; Broward County, FL; and Chicago, IL. With such a large collaboration it meant that the study procedures had to be approved by the CDC Institutional Review Board (IRB), the NORC at the University of Chicago IRB, six local research review boards in the four sites, and, because it is a federally funded data collection, the U.S. Office of Management and Budget (OMB).

School assignment—Each of the four sites partnered with 10 to 12 high-risk, urban, neighborhood-based schools with the understanding that these schools would be assigned to implement one of two preventive interventions for TDV— either the Dating Matters comprehensive approach or the standard approach. After being assessed for comparability on National Center for Education Statistics demographic data, these schools (initially $N = 46$) were block randomized to receive either the comprehensive or standard condition (Shadish, Cook, & Campbell, 2002). When important school differences were observed (e.g., two schools were K through 8th grade instead of 6th to 8th grade), schools were assigned to matched pairs and one school from each pair was randomized to one of the two conditions. With schools as the unit of randomization, we need to maintain 40 schools in the trial to maintain adequate power.

Longitudinal aspect of the design—The four sites are implementing in middle schools for four years (fall 2012 through spring 2016), and five cohorts of students are being followed from middle school into high school (through 2018). We recruited the 8th, 7th, and 6th graders from the first implementation year (Cohorts 1, 2, and 3, respectively) and are recruiting the 6th grade classes from the following two years of implementation (Cohorts 4 and 5, respectively; see Figure 1).

Sample recruitment and measurement—Outcome data are collected from three sets of respondents: middle school students (followed into high school), parents of those students, and middle school educators. Middle school students are approached for study participation through active parental consent forms distributed at school. In schools with four classrooms per grade or less, all students within the 6th, 7th, and 8th grades are recruited. Broward County schools are exceptionally large, so students are recruited from four randomly selected classrooms per grade per school. Students are surveyed twice per year (fall and spring) while in middle school, and once per year (spring) after matriculating to high school. In middle school, pencil and paper surveys are administered in classroom settings during the school day. In high school, the survey modalities are expanded to include in-school paper and pencil, online completion, and phone and in-person interviews.

Although we initially intended to survey parents for four years, we discontinued the parent survey in 2014 because of low participation rates (described below). The initial design involved recruiting three groups of parents (one parent per student): a random sample of parents (17%) of student survey participants in the comprehensive schools, a random sample of parents (17%) of student survey participants from the standard schools, and all parent program participants. Both mailed paper and pencil and online survey modalities were utilized, and a $2 incentive was provided in the first mailing. In the second year of implementation, a $25 incentive for a completed survey was offered. Parents were to be tracked longitudinally and surveyed twice per year.

All educators, defined as teachers, administrators, and other school staff, in all participating schools were encouraged to participate in an anonymous survey once per year. Surveys asked educators about topics such as school climate, awareness of dating violence, and other challenges within schools. Both online and paper and pencil modalities were offered.

Description and Discussion of Challenges Faced

According to the multisite evaluation framework proposed by Straw and Herrell (2002), the classification of the evaluation design for the Dating Matters initiative would likely fall somewhere between a multicenter clinical trial and a multisite evaluation. According to this framework, a multicenter clinical trial is the “gold standard” (p. 11) of evaluations involving multiple sites, and is defined within this framework as referring to “rigorous Phase III clinical trials involving more than one site that intend to employ identical interventions and evaluation procedures” (p. 10). The purpose of multicenter clinical trials, according to Straw and Herrell (2002), is to increase sample size, improve representativeness, and ensure that the intervention is efficacious in more than one setting or context. Although the Dating Matters evaluation is a multicity randomized trial that serves these purposes and at least intended to employ identical evaluation procedures and identical interventions, it falls short of the level of rigor identified within this framework for multicenter clinical trials due to the challenges we have faced along the way, resulting in less than identical evaluation procedures and implementation of the intervention over the course of the study. However, the authors of this framework state, “Our belief is that multiple site evaluations that depart from the multi-center clinical trial ideal are not necessarily weaker or less appropriate studies” (p. 11) and go on to point out that the parameters of a multicenter clinical trial are rarely possible in community settings. Therefore, we felt it might be informative for the field, both within the topic area of TDV prevention research and outside of it, to describe some of the challenges we have faced in implementing and evaluating Dating Matters in four distinct communities and how we have attempted to address these challenges in our efforts to conduct a multisite, cluster RCT of Dating Matters.

Site variability—A great deal of variation exists among sites with regard to infrastructure of the Dating Matters team at the site, school size, consent procedures, school/site differences related to research requirements, and community context, all of which affected consistency of both implementation of the comprehensive and standard approaches and of the evaluation. As mentioned previously, the implementation of the initiative was the responsibility of the four funded local health departments. Although CDC provided sites with the curricula, materials, training, and technical assistance for implementation of both the comprehensive and standard approaches, there was natural variation across sites in implementation of the initiative. For example, one site had teachers deliver the interventions, while another sites used subcontractors to deliver the intervention within schools, while the other sites used a combination of teachers, volunteers, and health department staff. Other examples of variations include the timing of the launch of particular comprehensive components and the standard approach across the school year. The nature of our collaboration with the health department sites, schools, and communities has dictated that we have not been able to maintain the level of control over the consistency of implementation as a multicenter clinical trial might require; however, we believe that such variations are not only to be expected within community settings, but they reflect the reality of how the Dating Matters comprehensive approach might be implemented in the future if dissemination seems warranted. We believe that allowing this variation likely led to greater ‘buy in’ and adherence to the main elements intervention than if we attempted to impose absolute standardization. We have maintained careful records of all variations in

implementation in order to account for them as much as possible in our analyses. Multilevel analytic models will account for the nested nature of the data (e.g., students within schools, schools within sites) and will incorporate process data about site-level variations in fidelity, dosage, and other implementation factors.

In addition to variability in implementation, we have also experienced site variation in evaluation procedures. For example, in one site we struggled with active parental consent form return to such an extent that we pursued and obtained IRB approval to implement a passive parental consent procedure starting in the second year of the evaluation, but we maintain active parental consent procedures in the other sites. With passive parental consent, parents of potential participants are sent a passive parental consent form that they are to sign and return only if they *do* not want their child to participate; parents who do not return a form are assumed to be providing passive parental consent for their child's participation. This obviously introduces a potentially significant variation between this site and the other three in terms of recruitment and representativeness of the sample, but it was a necessary variation given that the extremely low active parental consent rate in that site. As another example, the majority of the local IRBs approved longitudinal participation in the evaluation with initial active parental consent; however, one site's research review board typically requires active parental consent each school year for continued participation in a longitudinal study. In this case, we reached a compromise with this review board such that initial active parental consent would cover up to three years of middle school data collection if annual "opt-out" letters (e.g., parents signed and returned a form if they no longer wished their child to participate) were sent to parents. The opt-out letter was not required in the three other sites, creating a source of cross-site variability. As with variations related to implementation, variations in evaluation procedures are carefully documented when they cannot be avoided so they can be accounted for in analyses. Multilevel models will include variations in consent procedures (active versus passive) and any other evaluation-related variations that arise as site-level variables.

Separation of implementation and evaluation responsibilities—Because Dating Matters requires close collaboration among CDC, NORC evaluators, health departments, and schools, and because the sites and schools are tasked with the responsibility for *implementation* while CDC and NORC are tasked with the responsibility for the *cross-site evaluation*, some challenges have arisen due to competing responsibilities, and compromises have had to be reached. Although we had originally intended to pursue a passive parental consent procedure in all sites, and this was approved by our central IRBs, the sites made it clear that their research review boards would require active parental consent for student survey participation. This shift in the plan for consent procedures required substantial support from the health departments as the primary school partners. Health department and school staff spent a great deal of time and energy working on the evaluation-related responsibility of obtaining consent, which necessarily took time away from other implementation responsibilities. When response rates remained low despite substantial efforts, our projected 80% consent return rate had to be revised to 60%. Waiting to obtain the minimum consent return rate delayed baseline data collection, which then decreased time left in the school year for program implementation. In some schools that did not reach 60%

by mid-year (range of 36% to 58% returned), we eventually had to waive this minimum requirement of 60% of forms returned and proceed with collecting baseline data so that implementation would not be further delayed. We asked that these schools continue collecting consent forms to achieve a 60% return rate by the end-of-school-year follow-up, but schools were not always successful in meeting this threshold, meaning we had smaller percentages of students in our sample than originally intended from these schools.

Over time, we have faced decisions affecting both the evaluation design and implementation; our solutions have been reached through compromise in the context of collaborative relationships between the sites, the schools, CDC, and CDC's contractors, and we have done our best to keep accurate records of all instances in which such compromises were made. It is possible that some of the challenges of competing responsibilities could possibly have been avoided if the same party had been responsible for all implementation and evaluation activities; many successful RCTs of preventive interventions have been conducted by a research team who was responsible for all aspects of the intervention study, including intervention design, implementation, and evaluation (Foshee et al., 2005; Taylor, Stein, Mumford, & Woods, 2013; Wolfe et al., 2009). Nonetheless, despite the challenges faced here, there are distinct advantages to having separate entities responsible for implementation and evaluation; the implementation in such trials may be closer to how implementation would occur in real-world settings than is the case when the researchers are the implementers and are concerned with aspects of implementation critical to "clean" and rigorous evaluation, such as fidelity and consistency across sites. Therefore, independent evaluation is considered by some to be more objective and is often a criteria for inclusion in the highest levels of registries of effective programs, such as the Blueprints for Healthy Youth Development registry (Blueprints for Healthy Youth Development, 2014; Mihalic & Elliott, 2015). Those attempting this model of evaluation, however, must be aware that evaluation and implementation activities are closely linked and require a high degree of collaboration and sometimes compromise among the parties responsible for them.

School retention—One of the most significant challenges is retaining schools in implementation and evaluation activities. In many cases, when schools seemed to be contemplating withdrawing from the initiative, we have accommodated school needs (e.g., allowing schools to compress the suggested implementation schedule and implement sessions more frequently) and successfully retained schools. However, in cases where school loss could not be prevented, replacing schools has been our best alternative. In the first two years of implementation, 14 of the original 46 schools dropped out and were replaced with demographically similar schools that were subsequently randomized to condition. Of those that dropped out, two schools closed, and two schools indicated they withdrew because of concerns about curriculum content or fidelity guidelines (e.g., not being able to omit multiple curriculum sessions). In most cases, however, a definitive reason for dropping out was not provided, but competing demands and capacity to implement the curricula or to participate in the evaluation seemed to present significant challenges for many schools. Thus far, eight comprehensive and six standard schools have dropped out; we continue to monitor this closely, as a substantial imbalance would create a threat to internal validity (Campbell, 1969; Shadish et al., 2002).

School replacement is methodologically more advantageous than losing schools without replacing them, as it is critical to maintain power to detect statistically significant effects. However, this solution is not without limitations. Although the evaluation team thoroughly examined proposed replacement schools' available demographic information to ensure similarity to schools in the original randomization blocks, it is possible that unmeasurable differences existed between replacement and original schools (e.g., perhaps the first schools that the health department proposed were the most in need or the most willing to participate), and therefore randomly assigning replacement schools in subsequent randomization blocks may introduce a source of bias to the study (Hart & Fellabaum, 2008). However, our experience with the replacement schools was that their participation and context mirrored that of the original schools. Further, replacing schools later in the trial means the newly added schools have fewer than the anticipated four years of program exposure. Time of entry into the trial and length of implementation will be examined as additional covariates in multilevel analytic models to examine their potential influence on study results.

Parent engagement in consent and survey completion—Parent engagement in Dating Matters has been a significant challenge. Engaging parents is typically a difficult task for interventionists and researchers (Campbell, 1969; Foshee et al., 2005; Spoth & Redmond, 1992), but this process has been particularly difficult in Dating Matters schools and communities. Two aspects of parent engagement that particularly affected the evaluation design are (a) the return of active parental consent forms for student participation in the survey, and (b) parent participation in the parent survey. Although the CDC IRB originally approved a passive parental consent procedure for student surveys, local approvals in the four sites required active parental consent. We requested that consent forms be returned regardless of whether parents provided or refused consent for their child's participation. Health department, school, and NORC staff tried multiple methods to encourage consent form return (e.g., reminder calls to parents, engaging influential school staff in the process). Nonetheless, in one site, health department staff reported that schools found it almost impossible to get parents to sign and return free- or reduced-priced lunch forms, much less consent forms for participation in research. First-year return rates in that site were so low that we were able to obtain local IRB approval to engage in a passive parental consent procedure in subsequent years (contributing to site variation in consent procedures, discussed previously). We did not have OMB approval for middle school consent form incentives, but it is possible that offering a nominal incentive for the return of parental consent forms may have encouraged signature and return. The OMB Paperwork Reduction Action (PRA) approval process and some IRBs are hesitant about approving incentives for consent form return that might unduly coerce people into participating (or consenting for their child to participate). Other research teams might be able to obtain necessary approvals for incentives by using consent forms that both give and decline consent for participation, and then arguing that providing incentives for the *return* of signed consent forms would avoid the ethical pitfalls of coercion, as the incentive would be awarded for the return of forms regardless of whether consent was provided.

Participation in the parent survey has also been a significant challenge. Parents were mailed surveys and had the option of completing a hard-copy survey and mailing it back in an addressed, stamped envelope or completing the survey online. Parents were sent multiple mailings, the first including a $2 bill with no obligation. No increase in participation was observed even after we received permission to offer parents a $25 gift card if they completed the survey. Although mail surveys are less effective than many other recruitment methods (Dillman et al., 2009), available resources prohibited using more intensive methods. The lack of participation by parents is a true loss for our evaluation; parents represent a critical group of potential respondents for understanding both the potential impact of the parent program and for reporting on child behavior and elements of broader levels of the social ecology (e.g., neighborhood characteristics). Parents living in high-risk urban communities may have less time and less access to resources (such as computers and Internet service to complete online surveys) to participate in research than parents living in higher-resourced communities. Additionally, parents may have mistrusted the legitimacy of mailed solicitations for research participation. Efforts to engage parents in high-risk communities likely need to work to remove potential barriers to participation (e.g., engaging familiar community members to help with survey recruitment, providing incentives large enough to compensate for time spent participating, conducting in home visits with laptops or tablets for online participation) while building trust and relationships with parents, emphasizing the importance of their participation in the context of what is beneficial for their children.

School context and educator engagement—Working in under-resourced schools (vs. higher-resourced schools) has been a challenge. Evaluation efforts, at times, have been impacted by chaotic school environments; for example, data collections been cancelled or delayed because of communication challenges within the schools and between schools and the evaluation team (e.g., school staff responsible for gathering students were not informed by their school of the date and time of data collection; data collection team arrived at the school to learn that half of the students were on a field trip). Schools that are already overburdened with academic requirements or in fear of being closed or placed on probation often could not allocate full class periods for data collection, resulting in truncated time for administering surveys and missing data. In some areas, prioritization of addressing other risk behaviors or problems (e.g., peer violence, substance use) may have precluded investing time and effort into TDV prevention programs. As a result, educators at these schools have many competing responsibilities, which presented a barrier to educator participation in both the educator training and in the surveys.

Generally, challenges have been addressed by being flexible with the schools when possible and being vigilant about maintaining consistent communication with a reliable point of contact (POC) at the schools and at the health department. For instance, evaluation field staff have been accommodating to schools about arranging student survey data collection at times that are convenient for the schools, even when school requests are at odds with NORC's more typical approach for optimal survey administration (e.g., when schools request that all students be surveyed at once in a cafeteria or gym instead of in smaller, less disruptive classroom settings). NORC field staff work closely with the school and health department POCs to work out the best scenario for all parties and to prevent confusion at the school.

Having school POCs who are advocates for Dating Matters has been critical to establishing and maintaining school engagement and has improved our ability to maintain good communication and arrive at mutually beneficial solutions to challenges. Because of their relationships with the schools and school staff, our health department grantees were the main points of contact encouraging all educators to participate in the survey and encouraging staff at the comprehensive schools to take the Dating Matters educator training. It was challenging in all sites to get educators to participate in the training and the surveys because of competing priorities and already overburdened workloads. However, the infrastructure of the Dating Matters team in one site helped that site overcome this challenge. The health department at this site had subcontracted, as part of their Dating Matters funding, with the school district staff person in charge of prevention education in their site. This staff person was therefore able to incorporate both the survey participation and the educator training into already existing staff development trainings, such as the back to school trainings the educators attended before the start of each school year, and this prevented the training and survey from being seen as *additional* work by the educators. Having a Dating Matters staff person within the school district, who was able to incorporate Dating Matters participation into the educator's existing job responsibilities, greatly facilitated ensuring educator engagement in Dating Matters activities; this site consequently had the highest rates of participation in both the training and the surveys.

Although challenging, it is critical to continue to evaluate school-based interventions in the context in which they are implemented, including low-resourced and high-risk schools. Program effectiveness may be partially dependent on implementation context and may be influenced by factors such as socioeconomic and environmental conditions, organizational readiness, policy context, and features of the target population (Sable, Danis, Mauzy, & Gallagher, 2006). Dating Matters specifically targets students in high-risk urban schools, but conducting research within these schools has presented challenges for both intervention implementation and evaluation.

In sum, Dating Matters has faced numerous challenges specific to conducting a multisite, longitudinal cluster RCT in high-risk urban settings. Many issues are common in any rigorous evaluation of an intervention being implemented in schools and communities, including challenges maintaining a longitudinal sample and variations in community contexts and implementation. Despite the challenges that are generalizable to conducting rigorous evaluations in community and school settings and the challenges that are specific to Dating Matters (e.g., high-risk neighborhoods and schools, separation of implementation and evaluation activities), the original evaluation design of Dating Matters has not been compromised. We currently have 45 randomized schools in the study, and we maintain a growing sample of more than 3,000 students from these schools. The health departments, schools, CDC, and its contractors have worked collaboratively to achieve implementation with fidelity, to ensure careful adherence to randomization of schools to condition, and to guard against contamination. We are following students into high school to ensure sufficient time for intimate dating relationships to develop and to see the developmental effects of the interventions. Although the menu of evidence-based dating violence programs is growing, effect sizes remain small to modest, raising questions about the potential for a comprehensive approach to have broader public health impact than current standard practice.

The Dating Matters evaluation addresses this gap by conducting the first multicity, cluster RCT of a multicomponent intervention for TDV that compares the added value of implementing a multicomponent, comprehensive approach to an evidence-based program in a single grade. Understanding the challenges faced while conducting the evaluation may inform future rigorous evaluations of other interventions in similar settings.

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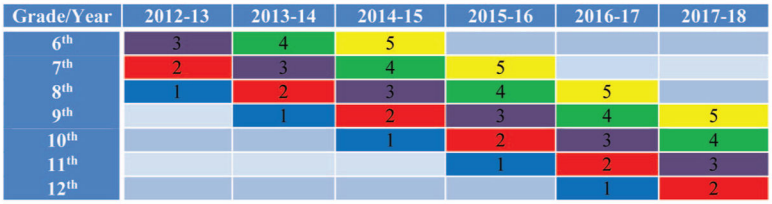

Figure 1.

A graphical depiction of the Dating Matters cohorts, by grade and school year. Cohort 1 is blue; Cohort 2 is red; Cohort 3 is purple; Cohort 4 is green; Cohort 5 is yellow. See the online article for the color version of this figure.

Table 1

Standard and Comprehensive Conditions in Dating Matters: Strategies to Promote Healthy Teen Relationships

Grade	Youth/Peers	Parent/Guardian	Educators	Communications	Policy
Standard practice					
6th	—	—	—	—	—
7th	—	—			
8th	Safe dates	—			
Comprehensive approach					
6th	Dating Matters for Students 6th Grade Program[a]	Parents Matter! for Dating Matters[a]	Dating Matters: Understanding Teen Dating Violence Prevention online training[a] http://vetoviolence.cdc.gov/index.php/dating-matters/	i2i Communications Campaign[a]	Efforts to inform local policy
7th	Dating Matters for Students 7th Grade Program[a]	Dating Matters for Parents[a]			
8th	Adapted Safe Dates	Adapted Families for Safe Dates			

[a]CDC has developed curriculum and communications strategies.