Evaluation of DELTA PREP: A Project Aimed at Integrating Primary Prevention of Intimate Partner Violence Within State Domestic Violence Coalitions

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Abstract

Background—Intimate partner violence (IPV) has been recognized as a public health problem since the late 20th century. To spur IPV prevention efforts nationwide, the DELTA PREP Project selected 19 state domestic violence coalitions to build organizational prevention capacity and catalyze IPV primary prevention strategies within their states.

Objective—DELTA PREP's summative evaluation addressed four major questions: (1) Did coalitions improve their prevention capacity during the project period? (2) Did coalitions serve as catalysts for prevention activities within their states during the project period? (3) Was initial prevention capacity associated with the number of prevention activity types initiated by coalitions by the end of the project? (4) Did coalitions sustain their prevention activities 6 months after the end of the project period?

Results—DELTA PREP achieved its capacity-building goal, with all 19 participant coalitions integrating prevention within their organizations and serving as catalysts for prevention activities in their states. At 6 months follow up, coalitions had sustained almost all prevention activities they initiated during the project. Baseline prevention capacity (Beginner vs. Intermediate) was not associated with the number of prevention activity types coalitions implemented by the end of the project.

Conclusion—Service and treatment organizations are increasingly asked to integrate a full spectrum of prevention strategies. Selecting organizations that have high levels of general capacity and readiness for an innovation like integrating a public health approach to IPV prevention will likely increase success in building an innovation-specific capacity, and in turn implementing an innovation.

Keywords

diffusion of innovations; evaluation; injury prevention/safety; violent behavior and prevention; women's health

For more than 20 years, the Centers for Disease Control and Prevention (CDC) has recognized intimate partner violence (IPV) as a public health problem that results in significant injuries, death, and long-term health and social costs. IPV refers to physical, sexual, and emotional forms of abuse by a current or former partner of same or opposite sex. Both men and women experience IPV; however, women more often than men experience IPV in any form, in multiple forms, and the most severe forms (Black et al., 2011; Breiding, Black, & Ryan, 2008; CDC, 2003, 2005, 2014; Heise & Garcia-Moreno, 2002; Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004; Tjaden & Thoennes, 2000). In 2011, one in four women and one in seven men reported they had experienced severe physical violence by an intimate partner in the CDC's National Sexual and Intimate Partner Violence Survey (CDC, 2014).

In the mid-20th century, the number of local agencies that provided IPV victim services and shelter greatly increased, and starting in the 1970s, state-level coalitions formed to support these local agencies (National Coalition Against Domestic Violence, 2008). Victim services include shelter; referrals to medical, social, and financial services; and court advocates.

Currently, all states and territories, as well as many tribal nations in the United States, have domestic violence (DV) coalitions that provide training, advocacy and victim services. Coalitions are nonprofit organizations with local service agency members. Most coalition executive boards initially comprised member agency leaders, but now many coalitions have at least some board members from other community sectors, such as youth-serving agencies and businesses. Coalitions range in size and structure, but all coalitions have paid staff and leadership, boards, operational budgets, and organizing documents. Most coalitions have similar roles within their states; they train and support member agencies, fund services, serve on state boards and committees, advocate for IPV victims, and interact with media outlets. In addition, many coalitions operate the state hotline, which refers callers to local services.

In 2002, the CDC funded 14 state DV coalitions to integrate a public health approach to *prevention* with their traditional *response* to IPV, including *moving upstream* to address IPV risk and protective factors, building strategies with the potential to effect population-level outcomes, and framing IPV within a social ecology. This program, called the Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) Program, was aimed at stopping IPV before it happens (CDC, 2009; Graffunder, Noonan, Cox, &

Wheaton, 2004). Ten state DV coalitions currently receive DELTA funding through DELTA FOCUS.

In 2007, CDC initiated DELTA PREP (Preparing and Raising Expectations for Prevention) in partnership with the CDC Foundation and the Robert Wood Johnson Foundation. The project's aim was to reach non-DELTA coalitions and to promote IPV prevention nationwide. Although the project was originally conceived as a DELTA expansion, in practice DELTA PREP differed in several important ways from its progenitor, including resources offered and project goals. Rather than being an expansion of DELTA, DELTA PREP grew into a second-generation program that used DELTA lessons to focus capacity-building within coalitions and streamline prevention efforts.

A major challenge for the IPV field is the lack of evidence-based strategies that have shown impacts on IPV behaviors, in addition to changes in knowledge, attitudes, and norms. Evaluated strategies commonly focus on adolescents in school settings but differ in their approaches, such as education on healthy relationships and gender norms, bystander skills training, conflict management, and environmental strategies, such as identifying hot spots for dating and peer violence (De Koker, Matthews, Zuch, Bastien, & Mason-Jones, 2014; Foshee et al., 1998, 2004; Miller et al., 2012; Miller et al., 2013; Taylor, Stein, Mumford, & Woods, 2013; Wolfe et al., 2009). Other strategies implemented in practice settings may have promise to effect behavior change because they apply social and behavioral theories and target IPV and sexual violence risk and protective factors, but they lack research that demonstrates their effectiveness. As such, CDC anticipated that DV coalitions may develop prevention strategies that could be evaluated, as well as serve as support systems for delivering evidence-based interventions as they become available (Wandersman et al., 2008). The project identified six key activities that coalitions support in their IPV response work where coalitions also could initiate or enhance their prevention work. These areas included training, state capacity building, media campaigns, programs, policies, and working with media outlets.

In this article, we present findings from the DELTA PREP Project's summative evaluation and discuss the implications for public health initiatives focused on integrating innovations that require extensive organizational change. We use the term *prevention* to refer specifically to primary prevention—defined as *preventing IPV from occurring in the first place*—with an emphasis on preventing IPV perpetration.

Project Participants

State DV coalitions that did not receive DELTA funds were eligible to apply to DELTA PREP. Of the 33 eligible coalitions, 31 applied, and 19 were accepted. The review panel selected coalitions based on (1) *general capacity* to support their existing operations, defined as having organizing documents, a strategic plan, an Executive Board that meets regularly, an Executive Director, a budget, and paid staff; and (2) *organizational prevention readiness*, defined as openness to a public health approach, organizational flexibility to integrate prevention, and leaders' willingness to participate in project activities and engage staff in a change process (Zakocs & Freire, 2015). Because organizational readiness influences the

adoption and maintenance of new innovations (Armenakis, Harris, & Mossholder, 1993; Weiner, 2009; Weiner, Amick, & Lee, 2008), DELTA PREP developed criteria to select coalitions that were highly ready to integrate prevention.

Project Design

The Interactive Systems Framework (ISF), first developed for work in CDC's Division of Violence Prevention, posits that both general and innovation-specific capacities are necessary to successfully support and deliver prevention programs (Flaspohler, Duffy, Wandersman, Stillman, & Maras, 2008; Flaspohler, Meehan, Maras, & Keller, 2012; Wandersman et al., 2008). In particular, established organizational structures, functioning, and climate (i.e., general capacities) are necessary, but not always sufficient, to implement new innovations. Innovation-specific capacities may include new knowledge, skills, and organizational capabilities needed to create desired changes. For DELTA PREP, the *innovation* was a public health approach to preventing IPV focused on preventing first-time perpetration or victimization of IPV, and the *desired change* was DV coalitions' integration of prevention with their traditional response work.

Although the original intent of the ISF was to link capacities needed to deliver and support a specific evidence-based program, DELTA PREP staff used the ISF to consider supports coalitions needed to implement IPV prevention work more broadly (Figure 1). When an innovation is a new idea or paradigm intended to change the way a whole organization approaches its work, its diffusion within the organization requires structural and cultural changes beyond building capabilities to implement specific interventions. Organizations must reconcile different points of view, disengage from some established practices, and modify infrastructure to support diffusion. Organizational leaders must be willing and able to engage staff and manage a change process, often through a series of stages (Boonstra, 2004; Butterfoss, Kegler, Francisco, 2008; Greenlaugh, Robert, MacFarlane, Bate, & Kyriakidou, 2004; Rogers, 2003; Williams, 2011). We defined the organizational flexibility, motivation, and willingness to integrate prevention as organizational *prevention readiness* to distinguish it from prevention capacity.

Coalitions as organizations were the project's main focus, but ultimately an organization is made up of individuals responsible for its operations. We designed project supports using principles known to promote new practices among practitioners, including training multiple staff members from an organization, creating opportunities to practice new skills, and providing tangible supports such as coaching, technical assistance (TA), feedback, and funding as practitioners adapt new skills to their organizational settings (Fixsen, Naoom, Blase, Friedman, & Wallace, 2008; Marquardt, 1999; Orton et al., 2006; Robertson, Umble, & Cervero, 2003; Umble & Cervero, 1996; Umble, Orton, Rosen, & Ottoson, 2006). In addition, we interviewed staff from all 14 DELTA coalitions to identify factors that influenced their ability to serve as catalysts for prevention in their states during the first 8 years of their work. We applied four common recommendations from DELTA coalitions to the project design: engage multiple staff members (vs. a single prevention coordinator), ensure leadership participation, create opportunities to learn from peers, and encourage relationships with partners that have common goals.

Project Aim and Theory of Change

Figure 1 shows DELTA PREP's theory of change. The project's overall aim was to accelerate state DV coalitions' building their prevention capacity. *Prevention Capacity* was defined as the *integration of prevention* into coalitions' organizational structures and functions. We hypothesized that coalitions would improve their prevention capacity through action planning, creating and documenting organizational changes, and reflecting on changes to make adjustments. We expected coalitions would begin or expand their role as prevention catalysts in their states by the end of the project period as a result of building their prevention capacity. *Prevention Catalyst* was defined as coalitions initiating or expanding IPV *prevention activities* in their states. We expected that coalitions would implement prevention activities with external partners and member agencies as the immediate result of improved prevention capacity.

Project Overview

The project provided eight supports to facilitate coalitions' developing and implementing action plans for organizational change (Years 1–3) and prevention activities (Years 2–3).

1. *Grant awards*: Each coalition received awards between $15,000 and $28,000 annually, averaging a total of $63,000 over the 3-year period. These funds primarily supported time and travel for coalition staff and leaders directly involved in the project, as well as planning activities and prevention training for all staff. In Years 2 and 3, coalitions could apply for supplemental awards ($3,000–$7,000) to support implementation of one or more prevention activities included in their action plans.

2. *Training events*: The project held 10 national and regional trainings. At least one coalition staff member and one leader (i.e., executive director or board member) participated in trainings. In Year 1, trainings focused on core public health concepts and their application to IPV primary prevention, the coalition prevention capacity assessment, action planning, and documentation processes. In Years 2 and 3, the project team used coalition action plans and participant feedback to identify training topics (e.g., media framing, using data sources).

3. *Technical assistance*: Project staff and consultants provided over 320 TA events over the 3 years coalitions received funding. Formats for TA included national conference calls with all DELTA PREP coalitions, quarterly calls with individual coalitions, and written feedback on action plans and documented changes. Individual TA was both proactive (i.e., anticipated and planned by project staff) and reactive (i.e., coalitions requested). TA content was designed to be both technical (e.g., documenting changes) and content based (e.g., guidance on specific prevention strategies).

4. *Coalition Prevention Capacity Assessment*: Coalitions completed the Coalition Prevention Capacity Assessment in Years 1 and 3. The assessment queried coalition staff and board members about their perceptions of coalition prevention-related structures, processes, staffing, resources, partners, and

leadership. Coalitions used their first assessment to inform their action planning process and the second to facilitate their reflection about progress and challenges in their prevention capacity building, as well as aid in sustainability planning for coalitions' prevention activities after the grant ended.

5. *Action planning resources*: Coalitions developed action plans that specified desired organizational changes and prevention activities; they updated and refined their plans twice a year and documented completed action items in the Online Documentation Support System (ODSS). Project staff and consultants provided workbooks, templates, inventories, training, and TA to support action planning. Inventories listed examples of organizational changes and prevention activities based on changes made by DELTA coalitions and research on coalitions; however, they were not exhaustive or prescriptive lists of changes and actions. We designed action planning to help coalitions leverage their existing resources and project supports to implement their plans within a brief timeline (Schober & Fawcett, 2015).

6. *Peer-to-peer support*: We defined five regional coaching hubs composed of staff from two to three DELTA coalitions (originally called coaches), and three to four DELTA PREP coalitions, assumed to have less experience with prevention. Coaching hubs were expected to meet monthly via telephone conference call, post meeting notes and other documents on the workstation, and meet during in-person trainings. We modeled coaching on action learning, an approach to adult learning that emphasizes problem solving through an iterative process of action and reflection (Marquardt, 1999; Marquardt &Waddill, 2004). We intended for coaching hubs to facilitate small communities of practice where DELTA coaches with prevention experience would help the group frame an issue, determine how to address it, and reflect on the process. In practice, however, both DELTA and DELTA PREP staff varied in their prevention experience, and coaching hubs established different approaches (Zakocs & Freire, 2015).

7. *Workstation*: The project offered an online workstation for coalitions to post documents and resources, edit group documents, discuss issues, and manage meetings. The workstation was intended to facilitate sharing within coaching hubs and to encourage a larger community of practice where all DELTA PREP grantees, DELTA coaches, and project staff would share information, network, and learn from each other.

8. *Online Documentation Support System*: Included in the workstation was a documentation system where coalitions recorded organizational changes and prevention activities. In addition to monitoring progress, coalitions were prompted to use data for reflection, process improvements, and storytelling. To promote consistency in documentation, the project team provided extensive training and TA on documentation, and at least two team members reviewed entries prior to quarterly TA calls with coalitions. We also used ODSS data for the project's summative evaluation.

Evaluation Overview

DELTA PREP had summative, process, and program improvement evaluation components (Zakocs & Freire, 2015; Zakocs, Hill, Brown, Wheaton, & Freire, 2015). We focused the summative evaluation on assessing whether or not the project met its primary goal of improved coalition prevention capacity demonstrated by organizational changes. We also examined prevention activities coalitions implemented within their states because prevention activities were the intended result of improved prevention capacity. We hypothesized that those coalitions that started with more (vs. less) prevention capacity would already have some foundation for prevention work and would be able to implement more types of prevention activities by the end of the project.

Evaluation Questions

Four questions guided the summative evaluation design:

1. Did coalitions improve their prevention capacity by the end of the project period?

2. Did coalitions serve as catalysts for prevention activities within their states by the end of the project period?

3. Was initial prevention capacity associated with the number of prevention activity types initiated by coalitions by the end of the project?

4. Did coalitions sustain their prevention activities 6 months after the project ended?

Measures

The project's two evaluators developed a 10-item index of *Prevention Capacity*, which included key coalition structures and functions (i.e., general capacities) where coalitions could start to integrate prevention (Table 1). Prevention Capacity items included the following: mission statement, strategic plan, staff time, staff structures (e.g., teams, work-groups), board structures (e.g., committees), training, partnerships, local member agencies, communication channels, and funding. Prevention Capacity index items were dichotomous, with 0 = *lack of prevention in the capacity area* and 1 = *prevention present in the capacity area*. Index scores were sums across the 10 items at T1 (i.e., baseline) and T2 (i.e., at the end of the project). We used the Organizational Change Inventory developed for action planning to initially identify index items and then refined the items during ODSS data coding.

We categorized *Prevention Activities* into six types using the Prevention Activity Inventory developed for action planning and ODSS data coding (Table 2). Types included (1) building state infrastructure, (2) training and events, (3) work with media outlets, (4) social media campaigns, (5) programs, and (6) policy activities. We summed the number of Prevention Activity types at T1, T2, and T3 (i.e., 6 months after the project ended).

Data Sources and Method

We measured coalition *Prevention Capacity* and *Prevention Activities* before the project started (baseline or T1) and at the end of the project (T2). In addition, we measured *Prevention Activities* 6 months after the project ended (T3). For baseline measures, we coded coalitions' original project applications, which included questions about prevention integration within coalition structures and functions at the time of application, as well any existing IPV prevention activities. We used data coalitions entered into the ODSS during the project to assess changes in measures at the end of the project. Coalitions entered their data at least quarterly. To increase consistency in documentation across coalitions and ensure that entries met the definitional criteria, project staff reviewed and coded all entries during the first 18 months and then provided feedback to coalitions on quarterly TA calls (Schober & Fawcett, 2015).

Six months after the project ended, we conducted phone interviews with all 19 coalitions. Interviewers reviewed prevention activities and prevention capacity changes coalitions documented during the project to verify that information was accurate and complete, and then asked about whether prevention activities within each of the six categories have been maintained or expanded.

Analysis

The coalition ($N = 19$) is the unit of analysis because the organization was the target of change and the specific number of changes documented across the 10 capacity areas sometimes varied due to timing or coalitions' specific context. For example, one coalition may have documented hiring two prevention staff as two changes because they occurred 6 months apart, whereas another coalition may have documented hiring two staff as one change. Ultimately, we were interested in whether coalitions made *any* changes across the 10 areas as indicators of beginning to integrate prevention versus trying to measure the amount of change in any given area.

To address evaluation questions 1, 2, and 3, we measured prevention capacity and prevention activities at baseline (T1) and at the end of the project (T2). To examine differences by initial prevention capacity (evaluation question #3), we created three groups at baseline that represented different levels of integration: Beginner (index score range = 0–2), Intermediate (index score range = 3–5), and Advanced (index score range = 6–10). The Advanced category indicated that coalitions had started to integrate prevention within the majority of the 10 organizational capacity areas measured. Finally, we compared coalitions' reports of prevention activities at the end of the project with their 6-month reports to examine the extent to which these activities were maintained.

We used median as the summary statistic and nonparametric tests for all statistical analyses. We used Wilcoxon signed-rank test to assess changes in capacity from baseline to the end of the project and Kruskal–Wallis test to examine differences in capacity and prevention activities by group status at baseline and at the end of the project. All statistical analyses were performed using SAS Version 9.3.

Results

All 19 coalitions documented changes in prevention capacity and prevention activities made during the project, and participated in 6-month follow-up interviews.

Did Coalitions Improve Their Prevention Capacity by the End of the Project Period?

At baseline, coalitions ranged from 0 to 5 areas where they had started to integrate prevention with a median score of 4 (Table 3). By the end of the project, coalitions had integrated prevention within 6 and 10 capacity areas with a median score of 8, a twofold increase in median score from baseline, which was statistically significant ($S = 95$, $p < .0001$).

At baseline, the three most common capacity areas where coalitions reported prevention capacity was in their mission statements ($n = 11$), partnerships ($n = 13$), and any staff time devoted to prevention activities ($n = 14$; Table 4). Most reports of staff time reflected participation in joint state planning activities for sexual violence and IPV prevention or participation in state committees or workgroups. Nine coalitions had at least one prevention goal in their strategic plan ($n = 9$). Few coalitions (1–3) had started to integrate prevention in the remaining six capacity areas at baseline.

By the end of the project period (T2), the most common organizational changes enacted were in four capacity areas: prevention funding (+14 coalitions), staff training (+15), work with member agencies (+16), and communication channels (+17; Table 4). Coalitions used two main strategies to increase *prevention funding*: obtaining grants and using their existing funds from the Family Violence Prevention Services Act (FVPSA), which all state DV coalitions receive for essential services such as emergency shelters, hotlines, counselling, and advocacy. FVPSA funds can also be used to support primary prevention, but no coalitions reported using these funds for that purpose at baseline. *Staff training* included integrating prevention concepts and increasing emphasis in orientation materials, cross-training for staff not currently involved in prevention work, and including prevention topics in regular in-service trainings. Work with *member agencies* was varied and often involved multiple types of activities within a single coalition. Common member agency activities were prevention training and TA, developing educational materials, and integrating prevention in existing certification trainings. Two coalitions chose to replicate the broader DELTA PREP model using assessment and action planning to focus member agency prevention efforts. The most common *communication* activities were developing messaging for distribution materials (i.e., logos, taglines), revised websites, prevention-focused articles in newsletters, and social media messages. When these messages were implemented with external partners as social media campaigns, they were counted under prevention activities. Few coalitions integrated prevention in staff ($n = 4$) and board ($n = 3$) structures.

Did Coalitions Serve as Catalysts for Prevention Activities Within Their States by the End of the Project Period?

At baseline, 10 of the 19 coalitions had initiated Prevention Activities, but most of the 10 had initiated only one type ($M = 1$; Table 3). By the end of the project, all 19 coalitions had

initiated Prevention Activities, ranging from 1 to 6 activity types with a median score of 3, a threefold increase from baseline, which was statistically significant (S = 85.5, $p < .0001$). At baseline, activities were mostly state capacity building, social media campaigns, and training and events (Table 5). Only three coalitions were implementing program activities with partners, and no coalitions had initiated policy activities or work with media outlets. At the end of the project, almost all coalitions initiated training and events ($n = 18$) with state partners, and about half were implementing programs with partners ($n = 10$), social media campaigns ($n = 9$), and state prevention planning ($n = 9$). Eight coalitions initiated policy activities, but only three had worked with media outlets (Table 5). CDC did not provide any federal funds to DELTA PREP grantees for project activities, which were supported in part by the Robert Wood Johnson Foundation. In accordance with U.S. law, no federal funds provided through FVPSA were permitted to be used by grantees for lobbying or to influence, directly or indirectly, specific pieces of legislation at the federal, state, or local levels. However, coalitions did integrate prevention with their usual policy activities funded by sources other than federal funds.

Was Initial Prevention Capacity Associated With the Number of Prevention Activity Types Initiated by Coalitions by the End of the Project?

Prevention Capacity—To examine whether initial Prevention Capacity was associated with the number of Prevention Activities implemented by the end of the project, we grouped coalitions based on their baseline Prevention Capacity index scores. The *Beginner* group included six coalitions that had integrated prevention in 0 to 2 capacity areas at baseline, with a median score of 0. The *Intermediate* group included the remaining 13 coalitions that had started to integrate prevention within 3 to 5 capacity areas at baseline, with a median score of 4. No coalitions scored within the *Advanced* group range (6–10) at baseline. Median baseline Prevention Capacity index scores for Beginner and Intermediate groups were significantly different ($\chi^2 = 12.42$, degrees of freedom [df] = 1, $p = .0004$; Table 6). At the end of the project, the Beginner group had started to integrate prevention within 6 to 8 capacity areas compared with 7 to 10 capacity areas for the Intermediate group. The increase in both groups reflected that most coalitions, regardless of their initial index score, had progressed to the Advanced group and integrated prevention in an additional 4 to 5 capacity areas from where they started. However, difference in median index scores at the end of the project between Beginner ($M = 7$) and Intermediate ($M = 8$) remain statistically significant ($\chi^2 = 4.38$, $df = 1$, $p = .0360$; Table 6).

Prevention Activities—At baseline, only one coalition in the Beginner group had initiated any prevention activities with a median score of 0, compared with about half in the Intermediate group with a median score of 1. However, the group difference in median number of prevention activities was not statistically significant ($\chi^2 = 1.585$, 1 df, $p = .2080$), which reflects that coalitions in both groups had initiated at most one type of prevention activity (Table 6). At the end of the project, Beginner group coalitions initiated between 1 and 5 types of prevention activities, with a median of 2.5 types, and Intermediate group coalitions initiated between 1 and 7 types, with a median of 3 activity types. These group differences were not significant ($\chi^2 = 0.460$, 1 df, $p = .5000$; Table 6). Hence, baseline

prevention capacity index scores (i.e., Beginner vs. Intermediate) were not associated with how many types of prevention activities coalitions had initiated by the end of the project.

Did Coalitions Sustain Their Prevention Activities 6 Months After the End of the Project Period?

Six months after the end of the project, coalitions had maintained their work on almost all of the prevention activities they had initiated during the project period (Table 6). The median number of types ($M = 3$) was the same at T2 and T3 (S = 4.5, $p = .6719$). Only one coalition reported no prevention activities at follow up. Table 5 shows the number of coalitions engaged in each activity type at follow-up.

Discussion

DELTA PREP achieved its capacity-building goal, with all 19 participant coalitions improving their prevention capacity and serving as catalysts for prevention activities in their states by the end of the project. Coalitions started the project at different organizational capacity levels (Beginner vs. Intermediate). In general, coalitions in the Beginner group had not initiated prevention activities at the project start, and Intermediate group coalitions initiated only a median of one of the six types. Our findings support that most coalitions had some (albeit limited) experience with IPV prevention in their organizations, but most coalitions had not moved outside their organizations to catalyze prevention within their states. By the end of the project, all coalitions had progressed to the Advanced level of prevention capacity, indicating they integrated prevention in a majority of the 10 capacity areas included in the Prevention Capacity Index. Coalitions initiated a median of three prevention activity types by the end of the project, and this was sustained at 6-month follow-up. Our initial hypothesis was that coalitions with higher prevention capacity at the start would engage in more types of prevention activities by the end of the project period because, in a sense, they had a head start. By the end of the project, however, both Beginner and Intermediate groups (except for one coalition) were implementing between three and six types of prevention activities, which exceeded our hypothesized expectation.

Several factors likely contributed to the success of both Beginner and Intermediate groups within the project period. The project *selected* coalitions with high general capacity and high prevention readiness. Selected coalitions had stable structures and functions where they could integrate prevention, and had organizational willingness and flexibility to engage in a change process to build their prevention capacity. Our findings are consistent with studies that link organizational readiness with successful implementation of evidence-based interventions and system-level changes in health systems (Armenakis et al., 1993; Weiner, 2009; Weiner et al., 2008).

The project staged action planning to focus on building coalition prevention capacity in Year 1 and then expanded to include prevention activities in Years 2 and 3. This allowed time for coalitions to engage in initial critical actions, such as dialoguing, learning about prevention, and increasing organizational commitment for prevention; such activities are examined in our process evaluation (Zakocs & Freire, 2015). In the first year, Beginner coalitions also

had time to catch up and integrate prevention into their organizations before selecting their prevention activities.

The project had eight supports to promote organizational change, and they were designed to be flexible and mutually reinforcing. We used our rapid feedback program improvement process to identify how coalitions perceived the usefulness of project supports and made adjustments based on participant feedback (Schober & Fawcett, 2015; Zakocs et al., 2015). Supports often worked together to reinforce new concepts and promote learning and action. For example, training was followed with ongoing TA and peer-to-peer support as coalitions developed their action plans. In addition, supports were flexible to accommodate coalitions' different contexts and developmental stages. For example, some coalitions found the peer-to-peer "coaching hubs" helpful to discuss ideas, while other coalitions preferred to have individual calls with project staff to initially explore ideas. The project's flexible supports enhanced our ability to engage with coalitions at different prevention capacity levels and to find combinations of supports that could meet the needs of most coalitions.

At 6-month follow-up, coalitions had maintained almost all of the prevention activities initiated during the project, and in some cases, they had expanded or initiated new prevention activities. Although 6 months is a limited period to measure activity maintenance, our findings indicate that coalitions were able to continue their prevention work without project supports. Coalitions received little funding during the project period, which may have prompted more focus on leveraging resources already in place—partnerships, funding, and state infrastructure—to initiate or build on existing prevention efforts. More than half of coalitions shifted part of their FVPSA funds to fund prevention activities by the end of the project, and another quarter made this shift within 6 months of the project ending. Several coalitions became more integrated in the state planning committees for sexual violence prevention, finding ways to integrate their similar IPV interests into the planning process. Most coalitions found new ways to work with existing partners. Yet another indication of sustainability are the ways in which coalitions tailored DELTA PREP supports to work with their member agencies, with two coalitions engaging in a full planning process with local members. Coalitions' improved prevention capacity likely prepared them for future prevention efforts that require greater funding and statewide collaboration.

There are important considerations for interpreting evaluation findings. One factor is the project's historical context. At the project's start in 2008, CDC was already funding 14 DELTA coalitions as well as state health departments to build capacity for sexual violence through the Rape Prevention Education Program. The diffusion of prevention in a national context was in motion. Nonetheless, the project brought evidence-based supports and structures to accelerate learning and actions, which resulted in coalitions at different starting point achieving comparable changes. Although we are not able to attribute coalitions' organizational changes and prevention activities solely to DELTA PREP, we did examine how the project specifically *contributed* to coalitions' efforts through the process evaluation (Zakocs et al., 2013).

Measuring prevention capacity and prevention activities is challenging because coalitions vary in size, budget, and context. Therefore, we developed measures with standardized

categories but allowed for variation in specific changes coalitions made within these categories. Because we used the coalition as the unit of analysis, we did not capture the amount of change that occurred within coalitions. In addition, coalitions generally documented only those organizational changes and prevention activities in their action plans, which may have resulted in underreporting for both measures if coalitions completed changes or activities that were not specified in their plans. Conversely, coalitions may have perceived documenting more changes as desirable because project staff was tracking changes. However, project staff also provided ongoing TA that emphasized the quality and feasibility of action plans versus number of changes, which likely reduced social desirability bias. Finally, because the evaluation was part of an existing initiative with a small number of coalitions ($N = 19$) purposely selected on prevention readiness, findings do not necessarily generalize to all state DV coalitions. Despite these limitations, our findings support that state DV coalitions can improve their prevention capacity and serve as catalysts for IPV prevention in their states.

Conclusion

State DV coalitions are important public health partners that have extensive experience in responding to IPV and violence against women more broadly. These coalitions can also serve as catalysts for IPV prevention by integrating prevention with their traditional work. Initiatives that work with organizations, such as coalitions, to integrate an innovation may have equal success with organizations starting with different levels of innovation-specific capacity when these organizations are equally motivated and willing to engage in a change process and the supports accommodate varying contexts and needs..

Acknowledgments

References

Armenakis AA, Harris SG, Mossholder KW. Creating readiness for organizational change. Human Relations. 1993; 46:681–703.

Black, MC., Basile, KC., Breiding, MJ., Smith, SG., Walters, ML., Merrick, MT., … Stevens, MR. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011.

Boonstra, J. Dynamics of organizational change and learning. Chichester, England: Wiley; 2004.

Breiding MJ, Black MC, Ryan GW. Chronic disease and health risk behaviors associated with intimate partner violence—18 U.S. states/territories. Annals of Epidemiology. 2008; 18:538–544. [PubMed: 18495490]

Butterfoss, FD., Kegler, MC., Francisco, VT. Mobilizing organizations for health promotion: Theories of organizational change. In: Glanz, K.Rimer, BK., Viswanath, K., editors. Health behavior and

health education: Theory, research, and practice. 4. San Francisco, CA: Jossey-Bass; 2008. p. 335-362.

Centers for Disease Control and Prevention. Costs of intimate partner violence against women in the United States. 2003. Retrieved from at http://www.cdc.gov/ncipc/pub-res/ipv_cost/ipv.htm

Centers for Disease Control and Prevention. Adverse health conditions and health risk behaviors associated with intimate partner violence: United States. 2005. Retrieved from www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm

Centers for Disease Control and Prevention. The domestic violence prevention enhancements and leadership through alliances (DELTA). 2009. Retrieved from http://www.cdc.gov/ViolencePrevention/DELTA/index.html

Centers for Disease Control and Prevention. Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization—National Intimate Partner and Sexual Violence Survey, United States, 2011. MMWR. 2014; 63(SS08):1–18. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6308a1.htm.

De Koker P, Matthews C, Zuch M, Bastien S, Mason-Jones AJ. A systematic review of interventions for preventing adolescent intimate partner violence. American Journal of Adolescent Health. 2014; 54:3–13.

Fixsen, DL., Naoom, SF., Blase, KA., Friedman, RM., Wallace, F. Implementation research: A synthesis of the literature (FMHI Publication No. 231). Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network; 2008.

Flaspohler P, Duffy J, Wandersman A, Stillman L, Maras M. Unpacking prevention capacity: An intersection of research-to-practice models and community-centered models. American Journal of Community Psychology. 2008; 41:182–196. [PubMed: 18307028]

Flaspohler PD, Meehan C, Maras MA, Keller KE. Ready, willing, and able: Developing a support system to promote implementation of school-based prevention programs. American Journal of Community Psychology. 2012; 50:428–444. [PubMed: 22618024]

Foshee VA, Bauman KE, Arriaga XB, Helms RW, Koch GG, Linder GF. An evaluation of Safe Dates, an adolescent dating violence prevention program. American Journal of Public Health. 1998; 88:45–50. [PubMed: 9584032]

Foshee VA, Bauman KE, Ennett ST, Linder GF, Benefield T, Suchindran C. Assessing the long-term effects of the safe dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. American Journal of Public Health. 2004; 94:619–624. [PubMed: 15054015]

Graffunder CM, Noonan RK, Cox P, Wheaton J. Through a public health lens. Preventing violence against women: An update from the U.S. Centers for Disease Control and Prevention. Journal of Women's Health. 2004; 13:5–16.

Greenlaugh T, Robert G, MacFarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organizations: Systematic review and recommendations. Millbank Quarterly. 2004; 82:581–629.

Heise, L., Garcia-Moreno, C. Violence by intimate partners. In: Krug, EG.Dahlberg, LL.Mercy, JA.Zwi, AB., Lozano, R., editors. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002. p. 87-121.

Marquardt, M. Action learning in action. Palo Alto, CA: Davies-Black; 1999.

Marquardt M, Waddill D. The power of learning in action learning: A conceptual analysis of how the five schools of adult learning theories are incorporated within the practice of action learning. Action Learning: Research and Practice. 2004; 1:186–202.

Max W, Rice DP, Finkelstein E, Bardwell RA, Leadbetter S. The economic toll of intimate partner violence against women in the United States. Violence and Victims. 2004; 19:259–272. [PubMed: 15631280]

Miller E, Tancredi DJ, McCauley HL, Decker MR, Virata MC, Anderson HA, … Silverman JG. "Coaching boys into men": A cluster-randomized controlled trial of a dating violence prevention program. Journal of Adolescent Health. 2012; 51:431–438. [PubMed: 23084163]

Miller E, Tancredi DJ, McCauley HL, Decker MR, Virata MC, Anderson HA, … Silverman JG. One-year follow-up of a coach-delivered dating violence prevention program: A cluster randomized

controlled trial. American Journal of Preventive Medicine. 2013; 45:108–112. [PubMed: 23790995]

National Coalition Against Domestic Violence. Timeline of the battered women's movement. 2008. Retrieved from http://www.ncdsv.org/images/NYCHRADSS_TImelineBWM_2008.pdf

Orton S, Umble KE, Umble KE, Rosen B, McIver J, Menkens AJ. Management academy for public health: Program design and critical success factors. Journal of Public Health Management and Practice. 2006; 12:409–418. [PubMed: 16912601]

Robertson KE, Umble KE, Cervero RM. Findings of the research reviews in continuing education in the health professions. Journal of Continuing Education in the Health Professions. 2003; 23:146–156. [PubMed: 14528785]

Rogers, E. Diffusion of innovations. 5. New York, NY: Free Press; 2003.

Schober DJ, Fawcett S. Using action planning to build organizational capacity for the prevention of intimate partner violence. Health Education & Behavior. 2015; 42(4):449–457. [PubMed: 26245933]

Taylor BG, Stein ND, Mumford EA, Woods D. Shifting boundaries: An experimental evaluation of a dating violence prevention program in middle schools. Prevention Science. 2013; 14(1):64–76. [PubMed: 23076726]

Tjaden, P., Thoennes, N. Extent, nature, and consequences of intimate partner violence: Findings from the National Violence Against Women Survey (Publication No. NCJ 181867). Washington, DC: U.S. Department of Justice; 2000. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/181867.pdf

Umble KE, Cervero RM. Impact studies in continuing education for health professionals: A critique of the research syntheses. Evaluation & the Health Professions. 1996; 9:148–174.

Umble KE, Orton S, Rosen B, Ottoson J. Evaluating the impact of the Management Academy for Public Health: Developing entrepreneurial managers and organizations. Journal of Public Health Management & Practice. 2006; 12:436–445. [PubMed: 16912605]

Wandersman A, Duffy J, Flaspohler P, Noonan R, Lubell K, Stillman L, … Saul J. Bridging the gap between prevention research and practice: An interactive systems framework for building capacity to disseminate and implement innovations. American Journal of Community Psychology. 2008; 41:171–181. [PubMed: 18302018]

Weiner BJ. A theory of organizational readiness for change. Implementation Science. 2009; 4:67. [PubMed: 19840381]

Weiner BJ, Amick H, Lee DS. Review: Conceptualization and measurement of organizational readiness for change: A review of the literature in health services research and other fields. Medical Care Research and Review. 2008; 65:379–436. [PubMed: 18511812]

Williams I. Organizational readiness for innovation in health care: Some lessons from the recent literature. Health Services Management Research. 2011; 24:213–218. [PubMed: 22040949]

Wolfe DA, Crooks C, Jaffe P, Chiodo D, Hughes R, Ellis W, … Donner A. A school-based program to prevent adolescent dating violence: A cluster randomized trial. Archives of Pediatric Adolescent Medicine. 2009; 163:692–699.

Zakocs R, Freire KE. The DELTA PREP initiative: Accelerating coalition capacity for intimate partner violence prevention. Health Education & Behavior. 2015; 42(4):458–470. [PubMed: 26245934]

Zakocs R, Hill JA, Brown P, Wheaton J, Freire KE. The Data-to-Action framework: A rapid program improvement process. Health Education & Behavior. 2015; 42(4):471–479. [PubMed: 26245935]
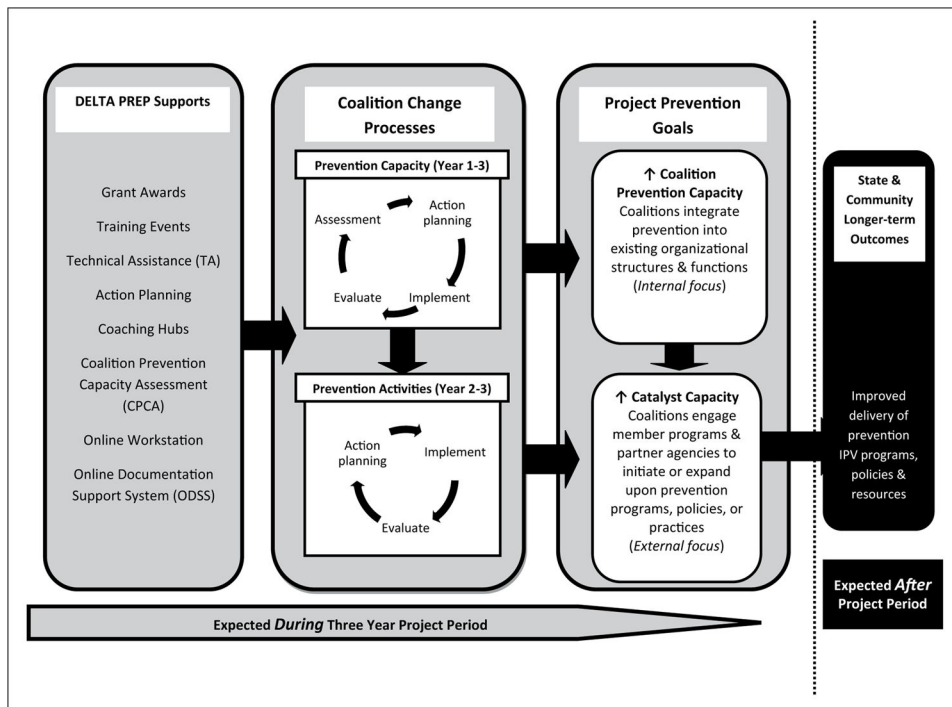
Figure 1.
DELTA PREP theory of change.

Note. DELTA PREP = Domestic Violence Prevention Enhancements and Leadership Through Alliances Preparing and Raising Expectations for Prevention.

Table 1

Prevention Capacity Index Items.

Index items	Definition of prevention integration	Examples of integrating prevention during DELTA PREP
Mission/vision statement	Vision and/or mission statements include prevention-related language and concepts	• Added language and definitions for healthy relationships, healthy sexuality, and a healthy community to mission and vision statements • Board approved a revised mission statement to integrate "prevention" and "promoting social change," with the coalition's intervention and victim service mission
Strategic plan	Strategic plan includes prevention goals	• Added a prevention goal to increase prevention efforts that engage men and boys to the coalition's strategic plan • Added three prevention goals to accomplish in the next 3 years to the coalition's strategic plan
Staff structures	One or more staff structures (e.g., teams, workgroups) includes prevention	• Formed a Prevention Team to develop and implement prevention activities in the coalition • Established a prevention department that will work with the policy and program departments to integrate prevention in coalition initiatives and policy agendas
Board structures	Board structure (e.g., committees) includes prevention	• Formally established a standing primary prevention seat on the Board • Board approved new bylaws that allows community members with prevention expertise instead of only allowing local agency Executive Directors
Prevention staff	Coalition hires prevention staff or revises staff position(s) to add prevention focus	• Hired a full-time prevention specialist • Hired a part-time grant writer to conduct research and to specialize in prevention funding grants • Transitioned AmeriCorps volunteer to full-time prevention staff member • Hired part-time associate to assist with prevention development and engaging men efforts
Partners	Partnerships formed for the purpose of implementing prevention activities	• Engaged a local foundation, the state high school athletic association, and state educator's association in integrating primary prevention into existing programming • Partnered with two Girl Scout councils and developed partnership statement
Local members agencies	Works with member agencies on *capacity-building* for primary prevention; does not include prevention activities implemented by or with member agencies	• Developed curriculum based on DELTA PREP model for prevention workers to engage faith leaders in IPV prevention strategies • Developed the first Child Witness and Prevention Certification Module that will be added to the Domestic Violence Advocacy certification (required by the state for member agencies)
Communication channels	Prevention is integrated within existing communication channels	• Feature a prevention article in every coalition newsletter • Launched a statewide primary prevention listserv to foster relationships and the exchange of resources between advocates working on prevention across the state • Developed Prevention Blog, linked to the coalition website prevention pages, Twitter, and Facebook accounts

Index items	Definition of prevention integration	Examples of integrating prevention during DELTA PREP
Training	Stand-alone prevention training OR prevention integrated with other existing staff/board training	• Incorporated prevention module into existing advocate training • Integrated prevention components within new staff orientation training and materials • Use quarterly in-service staff training to introduce prevention topics to all staff
Funding	External prevention funding or use of general funds for prevention	• Obtained a grant to work with youth to create a social marketing campaign in support of Indiana's teen dating violence prevention initiative • Obtained foundation funding to develop a bystander curriculum for boys 11 to 14 years old

Note. DELTA PREP = Domestic Violence Prevention Enhancements and Leadership Through Alliances Preparing and Raising Expectations for Prevention; IPV = intimate partner violence.

Table 2

Prevention Activity Types.

Activity type	Definition	Examples of prevention activities during DELTA PREP
Training and events	Sponsored or cosponsored a one-time or multiple prevention-related event that targeted individuals or agencies beyond member programs	• Held "The First 100" event honoring men who actively work against domestic violence • Held press conference where First Lady of the state read the "Proclamation for Prevention" adopted by the coalition's Board • Developed "td411" app for iPhone and Android. It provides information and tools that teens, their friends, and families can use to learn more about healthy relationships
Campaign	Conducted public awareness or social marketing campaign that focused on increasing awareness, knowledge, or norms related to IPV prevention	• Supported *My Safe Loving Home* campaign, targeted at children exposed to domestic violence • Implemented social marketing campaign aimed at adults promoting "safe spaces" for teens • Implemented the *White Ribbon* campaign, which engages men and boys to prevent gender-based violence
Program	Developed and/or implemented prevention programs in partnership with external partners or local member agencies, does not include capacity-building efforts with member agencies	• Implemented a middle school bystander strategy to reduce dating violence • In partnership with Girls & Boys State Training Schools, offered healthy relationships classes to teens • Implementing an adaptation of a bystander strategy with two Girl Scout Councils • Worked with state health department to develop a curriculum for providers who work with fathers to promote healthy and responsible sexuality • Developed a 6-week workshop series that culminates in an IPV social change project • Formed the Leadership Empowerment Action Project • Implementing Coaching Boys Into Men
Policy activities	Integrated prevention in the coalition's legislative agenda or existing policies; educated policymakers; or implemented a DV prevention-related policy by partnering with administrative agency	• Worked to pass Safe School Climate Act to strengthen bullying laws • Provided information to legislators on the "Sexting Bill," which defines "sexting" (harassment through texting) and has a provision for technology abuse education • Worked with partners to integrate the Healthy Teen Relationship Act in the existing Safe Schools Act, which addresses bullying in school • Educated legislators about what IPV primary prevention is and why it is important • Worked with state Departments of Education and Health and state sexual assault coalition to implement Heather's Law, which promotes healthy relationship curricula in schools
State capacity building	Developing state-level plans, processes, or infrastructure to support IPV prevention	• Initiated Men's Action Network • Aligned state planning for sexual violence and IPV • Provided ongoing technical assistance and training for community engagement aimed at men
Work with media	Working with media outlets to highlight prevention or inform how IPV is framed in media products	• Partnered with the state educational public television station to engage journalists in on media's role in framing and reporting domestic violence

Activity type	Definition	Examples of prevention activities during DELTA PREP
		• Conducted outreach, held editorial board meetings, and sent press kits to news outlets through the state about teen dating violence initiatives

Note. DELTA PREP = Domestic Violence Prevention Enhancements and Leadership Through Alliances Preparing and Raising Expectations for Prevention; IPV = intimate partner violence.

Table 3

Median Coalition Prevention Capacity Index Scores and Prevention Activity Types at T1 and T2 ($N = 19$).

Measure	Baseline (T1) median score	End of project (T2) median score	Point difference
Prevention Capacity Index score ($r = 1$–10)	4.0	8.0	+4.0[*]
No. of prevention activities ($r = 1$–6)	1.0	3.0	+2.0[*]

[*]
Statistically significant difference between Baseline and End of Project scores at p .05 level.

Table 4

Number (%) of Coalitions That Integrated Prevention in Each Capacity Area at Baseline and the End of the Project.

Prevention Capacity Index items	Coalitions that integrated prevention in the area ($N = 19$), n (%)		
	Baseline (T1)	End of the project (T2)	Difference from baseline to the end of the project (+)
Staff structures	3 (15)	4 (21)	1
Board structures	2 (10)	5 (26)	3
Any staff time	14 (73)	18 (94)	4
Form partnerships	13 (68)	19 (100)	6
Mission/vision statement	11 (57)	17 (89)	6
Strategic plan	9 (47)	16 (84)	7
Prevention funding	1 (5)	15 (78)	14
Staff training	2 (10)	17 (89)	15
Work with members agencies	3 (15)	19 (100)	16
Communications	1 (5)	18 (94)	17

Table 5

Number (%) of Coalitions That Implemented Prevention Activity Types at T1 and T2 ($N = 19$).

	Baseline	End of the project	Coalitions, N (%) Change from	Six months after	Change from
Activity type	(T1)	(T2)	T1 to T2	the project (T3)	T2 to T3
Outreach to media outlets	0 (0)	3 (15)	+3 (15)	3 (15)	0 (0)
Media campaigns	4 (21)	9 (47)	+5 (26)	9 (47)	0 (0)
Programs	3 (15)	10 (52)	+7 (36)	11 (57)	+1 (5)
State capacity building	4 (21)	9 (47)	+5 (42)	11 (57)	+2 (10)
Policy activities	0 (0)	8 (42)	+8 (42)	9 (47)	+1 (5)
Community training and events	3 (15)	18 (94)	+15 (78)	17 (89)	−1 (5)

Table 6

Prevention Capacity Index Scores and Prevention Activity Types for Beginner and Intermediate Groups.

	Prevention Capacity Index Score (*r* = 1–10)			
Capacity level	**Baseline *Mdn* (T1)**	**End of project *Mdn* (T2)**	**Six-month follow up (T3)**	**T1 to T2 point difference**
Beginner (*n* = 6)	0.0	7.0[a]	NA	+7.0
Intermediate (*n* = 13)	4.0	8.0	NA	+4.0

	No. of Prevention Activity Types (*r* = 1–6)			
Capacity level	Baseline *Mdn*	End of project *Mdn*	Six-month follow up	T1 to T2 point difference	T2 to T3 point difference
Beginner (*n* = 6)	0.0	2.5	3.5	+2.5	+1.0
Intermediate (*n* = 13)	1.0	3.0	3.0	+2.0	0.0

[a]Statistically significant difference in median score compared with the Intermediate group.