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From *Empower* to *Green Dot*: Successful Strategies and Lessons Learned in Developing Comprehensive Sexual Violence Primary Prevention Programming

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Abstract

This case study describes Kentucky's partnership with the Centers for Disease Control and Prevention (CDC) *EMPOWER* (Enhancing and Making Programs Work to End Rape) program to enhance the mission and services of existing rape crisis centers to include comprehensive primary prevention programming to reduce rates of sexual violence perpetration. The planning process and the successful implementation of a statewide, 5-year, randomized control trial study of a bystander prevention program (*Green Dot*), and its evaluation are described. Lessons learned in generating new questions, seeking funding, building relationships and capacity, and disseminating knowledge are presented.

Keywords

bystander interventions, empowerment evaluation, sexual violence prevention, socioecological model

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An evolution in the field of sexual violence (SV) is happening as rape crisis centers, practitioners, and government agencies are working together using the public health model to increase the emphasis on embedding primary prevention programming into their work. New conversations on how to build and test primary prevention programs that prevent first-time perpetration of SV are occurring. At the same time, the field has a growing interest in examining the effectiveness of bystander intervention prevention strategies to reduce SV. Here we describe the efforts of the Commonwealth of Kentucky to move from creating a plan to address primary prevention of SV using active bystander programming to the implementation of a 5-year, statewide, randomized control trial evaluation, *Green Dot*, funded by the Centers for Disease Control and Prevention (CDC).

This case study describes the paradigm shift that occurred when Kentucky worked to strengthen the collaboration between rape crisis center practitioners rooted in the history of the women's movement with public health professionals whose work emanated from the identification of and response to risk and protective factors across the social ecology. The article outlines the process that Kentucky engaged in to build a new plan to prevent SV and the implementation of a statewide program with an accompanying rigorous research evaluation project. A dialogue is presented regarding the importance of empowerment evaluation (EE), the socioecological model, and the bystander approach as guiding frameworks. The article concludes with a discussion of important lessons learned in five areas: generating and answering questions, seeking funding, building capacity, fostering relationships, and disseminating knowledge. The identification of lessons learned was generated using a case study approach. This qualitative data analysis strategy involved the in-depth examination of an approach or process (Yin, 2003). The case study presented in this article was based on document analysis of meeting and strategic planning session minutes of planning groups involved in Kentucky's *EMPOWER* (Enhancing and Making Programs Work to End Rape) and *Green Dot* programs, focus groups, key stakeholder interview transcripts, and process evaluation data.

Connecting the Women's Movement and the Public Health Field's Response to SV

Increasing attention on how to prevent SV and dating violence (Cook-Craig & Ciarlantu, 2012) created an opportunity to strengthen connections between the violence against women movement and the field of public health. Historically, the women's movement focused its SV prevention efforts on advocating for and designing a set of strategies to enhance awareness to both increase the likelihood that potential victims of violence could reduce their risk of victimization and to ensure that services were accessible and available for women who were victimized. The focus of these efforts resulted in landmark legislation and funding that ensured surveillance and services on all college campuses for what was often considered a high-risk population, young adults aged 18 to 24 (including the *Student Right-to-Know and Campus Security Act of 1990*, 20 U.S.C §1092[f] or the *Clery Act* and *Violence Against Women Act* [*VAWA*]). Studies on awareness and risk-reduction strategies found that although these strategies created short-term attitude or behavior change

(Anderson et al., 1998), they fell short of preventing SV (Gidycz et al., 2001; Gidycz, Rich, Orchowski, King, & Miller, 2009).

The field of public health operationalized SV as an *epidemic* and focused attention on increasing rigorous surveillance and prevention strategies designed to mitigate risk factors that increased primary prevention to reduce the prevalence of SV in society before victimization occurred (Haas & Doll, 2007). Although the history of SV prevention education funding supported individual awareness strategies, the evolution of the public health prevention funding refocused efforts toward primary prevention of the perpetration of SV (DeGue et al., 2012).

The public health movement also expanded the notion of prevention programming to include multiple levels of change across the socioecological framework of society. Although traditionally prevention education programming was focused on individual change, the public health perspective suggested that to achieve primary prevention of SV, change had to occur at four levels: the individual, relational, community, and societal levels (Dahlberg & Krug, 2002; U.S. Department of Health and Human Services, CDC, 2009). The inclusion of the socioecological model as a guiding framework provided a basis for a nuanced understanding of how to reduce risk and promote prevention. The use of this model allowed programs to be designed to mitigate the different risk factors associated with SV at each level of the socioecology. The U.S. Department of Health and Human Services, CDC (2009) developed a comprehensive list of identified risk factors of SV at each level of the socioecological model. Comprehensive responses to violence needed to address risk and protection at all levels, not just at the individual level (Dahlberg & Krug, 2002).

Strengthening the connection between the women's movement and the public health movement has created opportunities for new dialogue that strengthens the link between practice and research. Specifically, it bridged the national network of rape crisis center programs and coalitions, whose advocacy and practice expertise created the fabric of services available to victims, with the public health field, whose funding of evaluation research and expertise in addressing the health of the public as a whole has created the conceptual models that were essential to moving toward prevention of the problem. The promise of these new dialogues is the development of translational prevention models that connected research to practice and practice to research to ensure that conceptual prevention programs are reliably implemented and tested in the field.

The CDC, as the federal agency that provided formulary state funding for Rape Prevention and Education (RPE), was a primary force in leading this discussion. Over the past decade, the CDC has been engaged in working with a select group of states to provide training and technical assistance to pilot new strategies to build states' capacity to engage in primary prevention of perpetration of SV (DeGue et al., 2012). Kentucky, as one of those states, has seen an evolution in the state's understanding of how to approach its prevention work.

Kentucky's Journey From EMPOWER *to* Green Dot

Over the past 8 years, the Commonwealth of Kentucky has been on a mission to understand how to prevent SV. In 2005, Kentucky was invited to participate as an

unfunded partner in the CDC *EMPOWER* program. The 3-year project provided technical assistance and training to help build statewide capacity to engage in the primary prevention of the perpetration of SV. The project involved the development of a steering committee, called the State Capacity Building Team (SCBT), with membership from the state coalition for sexual assault programs, the state-level funding partner that distributed the state's allocation of the CDC RPE funding, and an identified evaluator. The SCBT was charged with forming and providing staff support to the State Prevention Team (SPT), which was established to create a Statewide Sexual Violence Prevention Plan. The purpose of this 5- to 8-year prevention plan was to create a set of goals to enhance statewide capacity to prevent perpetration of SV that encouraged the identification, implementation, and evaluation of strategies for the primary prevention of the perpetration of SV. At the end of the first 3-year project, Kentucky became a funded partner for *EMPOWER II*. This additional 3-year project focused on supporting states to work with their SPTs to develop an evaluation plan for the newly created state prevention plans.

Although the *EMPOWER* program was designed to build state-level prevention system capacity, the SCBT recognized the importance of having local communities and constituencies involved in the planning process. For this reason, a committee, called the One Project Committee, made up of representatives from each of Kentucky's 13 regional rape crisis centers, was formed to work parallel to the SPT on the strategy selection process. The initial charge of this committee was to work in conjunction with the SPT to engage in strategy selection and to assist the SCBT in identifying local capacity needs. Once the strategy was selected, this committee was renamed the Program Implementation Committee (PIC) and took the lead in ensuring successful statewide implementation of new prevention programming within the regional rape crisis centers.

Guiding Frameworks

Kentucky's experience in planning for comprehensive prevention programming was guided by three major frameworks. These included an EE orientation, a bystander approach to programming, and the use of the socioecological model to guide program selection and evaluation methodology.

EE. EE has been defined as "the use of evaluation concepts, techniques, and findings to foster improvement and self-determination" (Fetterman, 1996, p. 4). The focus of EE is to increase a group's ability to engage in its own evaluation, and as such, it is a capacity-building evaluation process (Cox, Keener, Woodward, & Wandersman, 2009). EE requires practitioners and researchers to engage and work together from early stages of the planning process, rather than at the point of program implementation or evaluation.

EE is based on the application of 10 core principles that drove the process of planning and conducting evaluation. These 10 principles include the following: improvement, community ownership, inclusion, democratic participation, social justice, community knowledge, evidence-based strategies, capacity building, organizational learning (OL), and accountability (Wandersman et al., 2005). Although the 10 EE

Table 1. Application of Empowerment Evaluation Principles to SV Primary Prevention Planning.

EE principle	Activities
Improvement	Construction of evaluation methodology data collection, analysis, and dissemination to promote individual professional and program adaptation based on results
Community ownership	All planning, implementation, and evaluation activities
Inclusion	Design of prevention planning, implementation, and evaluation teams/ committees; development of decision-making and communication protocols
Democratic participation	Design and execution of decision-making protocols
Social justice	Inclusion of participants on planning teams; selection of target populations
Community knowledge	Adaptation of strategies to target populations and local cultural norms; development of research methods and data collection strategies that can be implemented in the field
Evidence-based strategies	Selection of SV programs; design of methodology
Capacity building	Development of evaluation skills; design of activities that strengthen elements of the state and local infrastructure needed to plan and implement primary SV prevention strategies
Organizational learning	Generation of practitioner-informed evaluation questions; engagement in learning through reflection on evaluation research findings
Accountability	Dissemination and use of evaluation research findings; periodic review of progress on SV primary prevention plan

Note. SV = sexual violence; EE = empowerment evaluation.

principles were promoted at each step in planning, implementation, and evaluation, Table 1 summarizes the stages in which specific EE principles were most salient in Kentucky's experience.

Socioecological model. The use of the socioecological model guided Kentucky to vet primary prevention programming that affected outcomes on multiple levels of the socioecology. On the individual level, the impetus was to find a strategy that promoted not only attitude and knowledge change but also the adoption of new behaviors. On the relationship level, two changes were sought: cessation of violence perpetration and diffusion of prevention behaviors through peer influence across social networks. Kentucky also sought to select a strategy in which community change was affected by a shift in social norms that supported SV.

Bystander approach to primary prevention. Engaging bystanders has become an increasingly widespread prevention strategy to respond to SV (Cook-Craig & Ciarlantu,

2012) and was selected as the preferred approach to promoting primary prevention of SV in Kentucky. As a prevention strategy, the bystander approach trains individuals to respond to situations in which norms or behaviors that promote violence are present. Because the majority of individuals do not perpetrate SV, the bystander approach increases the likelihood of not just individual change but also community and social norms change, as the target population for change is everyone in the community, rather than just perpetrators or victims.

From Planning to Programming: The Implementation and Evaluation of *Green Dot*

Early in the planning process, it became clear that although EE is based on the promotion of evidence-based practice, few, if any, evidence-based strategies in the field of SV prevention existed. For Kentucky, this necessitated a commitment to the selection of a strategy that could be evaluated to assess evidence of effectiveness. This commitment led to a historic decision for the state that all rape crisis centers would pilot one program to the same target population, thereby allowing the state to plan and collect sufficient data to use a rigorous and randomized evaluation of the program.

The application of EE, the socioecological model, and selecting a bystander approach guided stakeholders through a planning process from program implementation to evaluation that resulted in an ongoing process guided by five major activities. These activities included the following: creating questions and determining needs; implementing an EE model to respond to questions and needs; engaging in the strategy selection process; building an evaluation research agenda; and reviewing process and outcome data to assess evidence of effectiveness of the selected strategy. The process by which this work was negotiated with various stakeholders, including practitioners, funders, researchers, local communities, and other stakeholders, is illustrated in Figure 1. To successfully make progress on each activity, stakeholders had to work together to generate questions, seek funding, build needed capacity, cultivate new and existing partnerships, and disseminate knowledge.

The culmination of the planning process was the selection of a signature strategy to be piloted in Kentucky to the high school population. This strategy, *Green Dot*, was selected because it met four priorities identified by local and state stakeholders. It was a strategy that focused on bystanders as the mechanism for prevention; could be adapted and applied to multiple populations across the life span; was comprehensive in nature based on the elements of comprehensive programming identified by Nation et al. (2003); and had the potential to prevent SV across the socioecology.

Green Dot, originally developed by Dr. Dorothy Edwards at the University of Kentucky for the college population, is a bystander primary prevention program designed to reduce risk of perpetration of all types of sexual and dating violence in high schools and colleges with the focus on power-based relationships (www.livethegreendot.com). Although many men and women are not violent, *Green Dot* raises consciousness regarding all persons' responsibility to identify and engage each other to reduce violence and teaches students how to become active *bystanders*, who respond to situations that keep

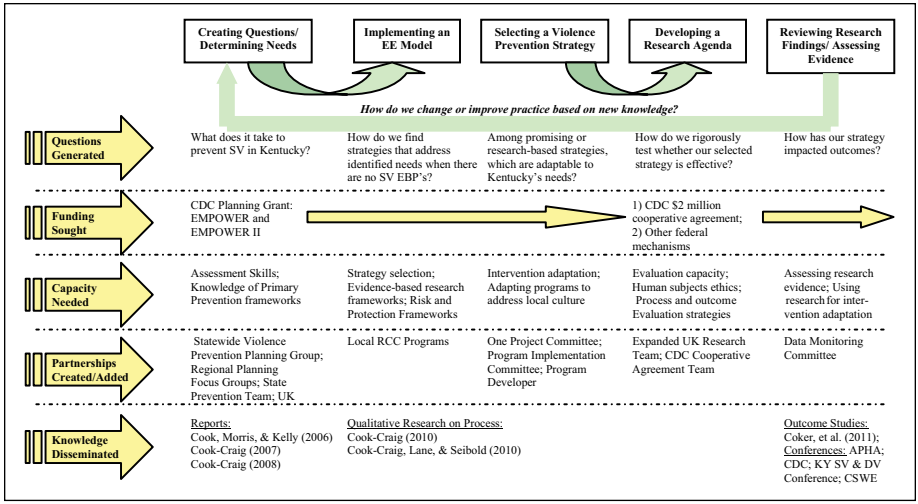

Figure 1. Kentucky's sexual violence prevention planning to programming model.
Note. EE = empowerment evaluation; SV = sexual violence; EBP= evidence-based practice/program ; CDC = Centers for Disease Control and Prevention; RCC= rape crisis center; KY= Kentucky; DV= domestic violence.

each other safe and confront social norms and individual actions that make violence possible. Engaging active bystanders involves two phases: (a) a motivational/persuasive speech given to all students, school leaders, faculty, and administrators to build an awareness of the problem of partner and SV and to motivate students to participate, and (b) a 5-hr skills training on preventing perpetration behavior, barriers to intervening, patterns of perpetration to inform bystander responses, and ideas for strategies to diffuse the message to their peers given to identified influential school leaders using a Popular Opinion Leader (POL) selection strategy (Kelly, 2004).

Once *Green Dot* was selected, the planning process shifted to the implementation design and the search for funding to evaluate the pilot. The goal of testing the effectiveness of *Green Dot* using a rigorous evaluation strategy guided many decisions in the construction of the pilot. In addition to all rape crisis centers implementing one statewide prevention program, this goal was the deciding factor in implementing the strategy with a specific target population—high school students, aged 14 to 17. The random selection of matched pairs of intervention and control schools in each of Kentucky's 13 regions (26 high schools in all) allowed for a sufficient number of sites and students to test hypotheses associated with the prevention program.

By choosing one program to be implemented with a sufficient number of students to test for significant change, the SPT, the SCBT, and the PIC were able to engage a larger team of researchers. This expanded team was able to identify and submit funding proposals to seek needed evaluation funds. Because the research team worked closely with practitioners from the time the proposal was in the development stage, the result was a rigorous methodology that was vetted for its ability to be implemented in

a practice and school setting. In September 2009, the University of Kentucky, with the state coalition as a funded subcontractor, was awarded a 5-year cooperative research grant to test *Green Dot* in the high schools (5U01CE001675). The research study tested the effectiveness of *Green Dot* in both increasing active bystanding behaviors and decreasing rates of violence victimization and perpetration over time. (For a more comprehensive description of the *Green Dot* program and the evaluation methodology, see Cook-Craig et al., 2014.)

As part of the cooperative agreement, a team of CDC researchers began to collaborate with the evaluators and practitioners in Kentucky as the evaluation trial was implemented. This brought a new type of expertise to the table, which became instrumental in helping to think about the evaluation and research challenges.

The stakeholders all agreed that the ultimate goal of the program was the overall prevention of violence in the school community, and it was important to track both increases in active bystanding behaviors and reductions in violence outcomes. Although most studies on bystander behaviors measure changes in beliefs or attitudes or intention to engage in new behaviors, there were few exceptions that measured actual bystanding behaviors as a result of training (Banyard, Moynihan, & Plante, 2007). It was important to both the research team (who wanted to expand the knowledge base on the effectiveness of bystander training) and the practitioners (who wanted to be able to reliably state that participation in the *Green Dot* program changes students actions) that an evaluation methodology was created that tracked new bystanding behaviors over time post-training. Tracking the rates of violence each year in the implementation and control schools was also a mutual goal of the stakeholders who came from both research and practice backgrounds. The rape crisis centers and educators were clear from the beginning in expressing the need for a new type of knowledge. Although they conveyed confidence in their ability to use evidence-based strategies and effective interventions to respond to the needs of victims after violence had occurred, they felt frustrated that the rates of violence in the state and nationally had not decreased over time. As the group planned a strategic set of actions to engage in primary prevention work, they wanted to be able to show that, over time, prevention programming results in a real reduction in violence. This meant that the coalition and the rape crisis centers had to partner with researchers to do something that they had long discussed but had not found a mechanism to do: annual surveillance of victimization and perpetration of violence. In addition, they had to track whether or not bystander behaviors were diffused from trained students to non-trained friends in their peer groups. This was seen as critical, because peer diffusion is a key component of the scientific basis from which *Green Dot* was created (http://www.livethegreendot.com/gd_research_science.html).

Adapting the Model

The collaborative work of the program developer, the evaluation researchers, the SCBT, and the practitioners delivering the program resulted in two modifications to the *Green Dot* model originally developed for the college population. The first adaptation was done by the practitioners and program developer to adapt language, example videos, and other relevant content into the curriculum to meet the developmental needs

of the high school student rather than a college student. Because this was an embedded process between developer and presenters, it increased the likelihood that adaptations would be developmentally relevant to high school students. At the same time, it decreased the likelihood that adaptations would be contrary to the scientific basis of the program.

In addition, individual educators were encouraged to adapt examples and language to make the program relevant to the local culture of students in their high schools. Because the 13 rape crisis center program educators met regularly at PIC meetings, they were able to work together to share information and to ensure adaptation to local culture was consistent with the scientific basis of the program.

Lessons Learned

Each of the major parts of the process illustrated in Figure 1 generated a set of lessons. Systematic reflection on actions taken, which is a critical component of the EE principle of OL (Wandersman et al., 2005), helped the SCBT to use process evaluation data and artifacts of the work to identify lessons and make changes or adaptations as necessary. Major lessons in each of the five areas of work are discussed below.

Generating and answering questions. Perhaps, the most critical component of the success of *EMPOWER* in preparing Kentucky to successfully plan, secure funding for, and implement the pilot of *Green Dot* in the high schools was the use of the EE framework. The adoption of principles such as inclusion and community ownership resulted in a deliberate process of both generating and answering questions. First, it broadened the notion of who could ask relevant questions and whom to involve in the process of generating questions. The group found that each step of the process of selecting and adapting strategy and building an evaluation pilot in the high schools generated its own set of new critical questions.

Second, as the planning process and program implementation process unfolded, there was a realization that there were three relevant perspectives to consider when answering each question: (a) the answer that adhered to funding requirements; (b) the answer that met practitioner needs in the field; and (c) the answer that was most rigorous from an evaluation research perspective. Over time, the group became much more deliberate in answering questions generated and were careful to seek the perspective of all three groups, funders (both the CDC and the RPE funder in the state), the research team, and the practitioners (including center directors, educators, schools, SPT, and Community Prevention Team [CPT] members), prior to settling on an answer. The group also became more intentional in creating a process that ensured decisions were communicated to *all* parties involved. For instance, a decision made on changes in research methodology was finalized after seeking advice from the educators and centers participating in the project; the decision was then communicated back to the group with careful consideration to pass information to people who could not participate in any particular meeting or call. Although this often meant that questions were answered less quickly, it also meant that the answers were more likely to support the work of all parties participating in the implementation and testing of *Green Dot*.

In addition, the application of another EE principle, OL, was influential in the question generation process. OL is a systematic strategy for team learning in which members produce actionable knowledge to answer a question that is considered a professional dilemma (Sabah & Cook, 2008). In this case, Kentucky began with the learning question, "What does it take to prevent violence in Kentucky?" OL recognizes that sufficient evidence-based practices do not exist for some social problems and provides a systematic framework for strategy selection and testing whether or not evidence-based practices (EBP) are available (Sabah & Cook-Craig, 2010). Given the lack of evidence-based strategies for primary prevention of SV, stakeholders in Kentucky found that they could not rely solely on the EBP literature and thus had to generate an answer to the question from the best available research and local knowledge. The OL process encouraged development of these actionable solutions. It also promoted reflective learning and rigorous evaluation to assess whether the original question was answered or further strategy refinement or development was needed (Sabah & Cook-Craig, 2010).

Seeking funding. Action on this project was often dictated by the *EMPOWER* and research grant funding cycles, creating an artificial timeline that had to be adhered to. A difficult dilemma in the nexus between planning and strategy implementation was how to decide the point in the planning process when implementation could begin. Initially, the SPT and the PIC wanted to implement the strategy as soon as possible and, in some cases, before the evaluation was designed and funded. Once *Green Dot* was selected as the pilot strategy, the momentum and excitement that had been generated in the planning process made it difficult to contain strategy implementation while the research team engaged in the Institutional Review Board (IRB) review, instrument pilot testing, and data collection methodology finalization. In short, the SCBT found that stakeholders much preferred action over planning, and significant effort was required to make the case that strategically planning each step was needed to ensure optimal outcomes. One helpful approach to this problem was to engage practitioners to become part of the research team and to train them to become data collectors. Although this was initially done as a practical step to have enough trained staff on hand to collect data at each of the 26 schools, the SCBT found it was also critical in building the capacity of practitioners to understand the complexity of planning and implementing an evaluation that could generate the type of evidence of effectiveness that they desired.

Practitioners found this problem was replicated on the local level when they began to facilitate meetings of their CPTs. The initial charge of the CPTs was to create Community Prevention Plans that would identify goals, objectives, and strategies that supported new active bystanding in the high school community. Often, however, CPTs favored brainstorming and engaging in activities without completing a strategic plan. Local providers found they needed skill building in engaging groups to plan just as the SCBT did.

Building capacity. At each stage of the progression on the state's movement from planning through to implementation and evaluation, new types of capacity needed to be built to assist team members to complete tasks successfully. Figure 1 outlines the major new types of capacity that were identified and built throughout the transition.

Initially, a significant investment of time had to be spent by the SCBT, the SPT, and the PIC on developing a shared definition and understanding of primary prevention. Originally, the SCBT engaged the team to define the difference between primary, secondary, and tertiary prevention but found that members (including themselves) often confused the difference between the three. Working with the CDC and the other states in the *EMPOWER* collaborative, Kentucky shifted its approach to using a definition of primary prevention that differentiated activities as targeting violence *before* or *after* the violence occurred. Using this approach, primary prevention strategies were identified as those that tried to stop the violence *before* it occurred. The framework of targeting goals, activities, and strategies whose intention was to keep violence from occurring in the first place rather than responding after violence had occurred proved to be a simpler and effective strategy of creating a shared definition of what primary prevention means.

The strategy selection and adaptation process required building capacity of practitioners to critically assess the evidence base (or lack of evidence) of primary prevention strategies for SV perpetration. In addition, a nuanced understanding of the program adaptation process was needed. Significant time and effort were expended by the SCBT and the PIC to ensure that the program was adapted in ways that supported the scientific basis of *Green Dot*. To do this, however, training and technical assistance in how to adapt programs were needed. Furthermore, because the state had decided to create a statewide pilot evaluation, adaptations had to be adopted by all centers and all educators to ensure fidelity to the model and uniformity in the delivery of the program across sites during the evaluation period.

Assessment of capacity of the state prevention system and individual capacity of team members showed the state was most in need of strategies to build evaluation capacity, including designing process and outcome evaluation methods and understanding research findings based on data collected. The decision to have educators and center directors trained as data collectors not only helped them understand the importance of how funding timelines had to influence when strategies would be implemented, it also created a natural and effective opportunity to build the capacity of practitioners to engage in evaluation. Over time, educators became adept at bringing research challenges to the table, at suggesting workable solutions to research challenges brought to them, and at suggesting new research questions or identifying types of analysis that they needed to further their work. Because the EE framework was used at the beginning of the planning process rather than at the point of designing the evaluation methodology, community ownership of the evaluation had been established. This increased the willingness of practitioners to build evaluation capacity, although they began the process self-identifying as "not being researchers."

Cultivating relationships. Perhaps, the most important lesson in cultivating relationships was the realization that building meaningful and authentic relationships of stakeholders from various backgrounds took time. Practically speaking, this meant allowing for and facilitating relationship-building activities. Although this slowed the work at the initial phases of the planning process, it also had two important impacts. First, it created a greater sense of individual buy-in by team members, who were given opportunities to

explore the importance of their professional role at the table. Second, the initial investment in relationship cultivation created a sense of trust among team members that influenced the depth of discussions and created safety in the critical exploration of new ideas about how to prevent violence. Once the knowledge of how to cultivate relationships was well understood at the state level, the SCBT worked to build the skills of rape crisis center staff to be able to replicate successful strategies in relationship cultivation of the members of their local CPTs.

Several components of the process necessitated a shift in the state's approach to collaboration and partnership. The *EMPOWER* grant as well as the EE paradigm encouraged rethinking the roles of the state coalition and the local rape crisis centers as *experts.* Instead, it encouraged a process that sought meaningful participation of both *traditional* partners (those individuals and entities whose main function was prevention of and intervention in SV) and *non-traditional* partners (those individuals and entities whose work was related to or affected by SV). This broadened the discussion of who should be at the table.

At the same time, the adoption of a bystander approach to prevention by the state reinforced a challenge to the notion of "experts" solving the problem of SV. Instead, it led to open dialogue, the creation of goals and objectives, and strategy selection that sought to broaden ownership of the problem. This perspective promoted the realization that as every person was a bystander to SV and social norms that promoted violence, every person had a responsibility to own the problem and a piece of the ultimate solution that moved the state toward achieving its goal of preventing violence before it occurred.

One benefit of having a greater diversity of voices at the table was the depth of ideas and solutions that were generated from participants with different lenses helping to guide decision making. For instance, by bringing together a social justice perspective emanating from the violence against women movement with the sociological model of the public health perspective, a more unified outlook was created in the state of the continuum of practice from prevention to intervention. The use of non-traditional partners with different lenses was also a hallmark of both the work of the SPT in strategy selection and in the development of the *Green Dot* strategy itself. In the strategy selection process, the SPT was faced early on with the problem of using an EE process that had a core principle of promoting the use of evidence-based strategies in a field that did not yet have a set of tested evidence-based primary prevention programs. Their solution was to invite experts from other prevention fields to the table for issues that had more evidence-based programming at their disposal, such as substance abuse and HIV prevention. By approaching the strategy selection process this way, the team broadened their thinking about how to elevate the importance of evidence in the conversation in the absence of obvious evidence-based SV primary prevention strategies. The selection of *Green Dot* as the strategy to pilot across the state became attractive to the group because it incorporated elements and practices that came from evidence-based strategies identified in other fields (see http://www.livethegreendot.com/gd_research_science.html for a description of the scientific basis of the *Green Dot* strategy).

Finally, consideration of the public health approach in the process of building an inclusive team encouraged the SCBT to use the socioecological model as a way of ensuring community, regional, and state participation in the prevention planning and

implementation process. Just as the socioecological model suggests that to successfully change social norms that promote violence intervention, one has to address risk factors and promote protective factors across the social ecology (Dahlberg & Krug, 2002), the SCBT realized that to achieve primary prevention of the perpetration of SV in Kentucky high schools, relationships had to be cultivated in the schools where programming would be implemented, in local communities, and at the state level working in conjunction with national leadership. Figure 2 illustrates the levels of participation that were cultivated to ensure participation and success in the project.

Combining multiple paradigms and working across disciplines, however, was a challenge. To overcome this challenge, it became necessary to create a process that built in time for the group to learn how to assess questions from different lenses. One way this was achieved was by building in opportunities for members of the various planning committees to both participate in activities and to participate in developing and delivering components of assessment and training to their fellow members. What the group found was that although this took valuable meeting time, it also fostered two unintended process outcomes from a capacity building perspective. First, it allowed people to participate in the process by bringing their expertise and strengths to be table. In other words, it fostered the EE principle of using local knowledge.

Second, it allowed individual members to build their knowledge and capacity as part of participation on the team. From the beginning, the SCBT approached its work from the perspective that committee members and stakeholders would not only give to the process, but that the team would identify what they needed and capitalize on opportunities to engage in professional development and capacity building of the committee members as well. Building the individual and group capacity of team members to participate in community coalitions and committees is identified in the literature as an important component of successful community coalitions (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001).

Disseminating knowledge. As a project influenced by EE, the design of dissemination of knowledge was constructed with the philosophy that assessment information and data should be used in two ways. First, process evaluation data were used as a source of help to guide the implementation of the project with fidelity internally. Second, outcome data were used to test the impact of the program on active bystanding that would be shared with the broader external practice and research community. To meet the needs of different constituencies with different capacities, questions, and interests in examining data and study findings, the importance of having at least one key person on the core planning team who could translate conversations into language that was accessible and salient to both researchers and practitioners was key.

In addition, diversity in the choices of audience and venues for dissemination of the work was considered critical by the group. It was also essential to have a dissemination plan that prioritized informal discussions and formal presentations of assessment and evaluation data. The team sought opportunities to do informal presentations to multidisciplinary groups of non-traditional partners, to community partners of the CPTs in each region of the state, and to schools at critical points in the data collection process. Formal presentations were delivered at local and state conferences as well as

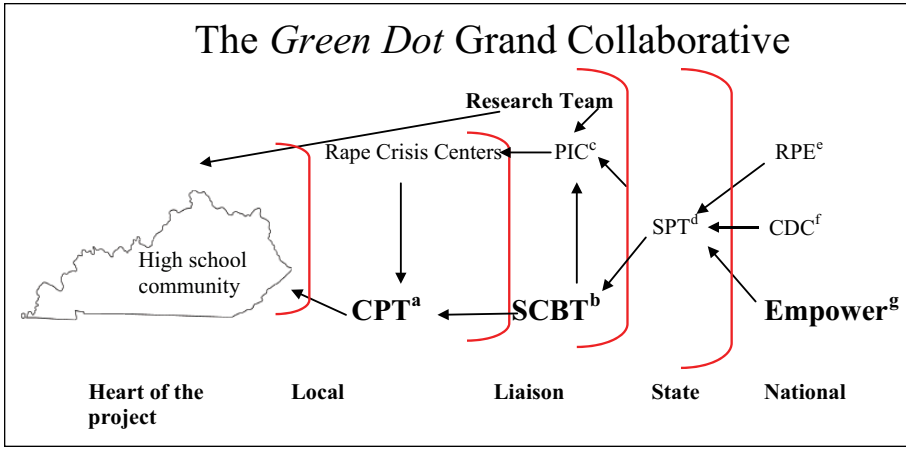

Figure 2. Kentucky's collaborative primary prevention of sexual violence team.
[a]Community Prevention Team.
[b]State Capacity Building Team.
[c]Program Implementation Committee.
[d]State Prevention Team.
[e]Rape Prevention and Education Program.
[f]Centers for Disease Control and Prevention.
[g]Empowering and Making Programs Work to End Rape.

at national conferences in a variety of disciplines including public health, social work, and criminal justice.

Conclusion

The success of *EMPOWER* to *Green Dot* was more than the creation of a living State Violence Prevention Plan that continued to be implemented, the historic collaboration of all state rape crisis center programs to engage in a statewide violence prevention program, or the receipt of a research evaluation cooperative grant that allowed the state to build on the evidence base of what worked in primary prevention of SV perpetration. The success of *EMPOWER* to *Green Dot* was in the willingness of practitioners to create a strategic process and to take new risks to answer fundamental questions about how to prevent violence. What Kentucky created when they agreed as a state to interweave prevention and intervention work was a newfound hope that the elimination of violence was possible. What they learned was that this hope would be closer to becoming a reality if they coalesced. They found that it was the power of the collaboration, as a state and as individuals, which enabled them build the capacity needed to push their work to the next level. By trusting the process, they gained confidence that although all of the answers to their questions did not yet exist, they had the ability to find and use them together.

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References

Anderson, L. A., Stoelb, M. P., Duggan, P., Hieger, B., Kling, K. H., & Payne, J. P. (1998). The effectiveness of two types of rape prevention programs in changing the rape supportive attitudes of college students. *Journal of College Student Development*, *39*, 131-142.

Banyard, V. L., Moynihan, M. M., & Plante, E. G. (2007). Sexual violence prevention through bystander education: An experimental evaluation. *Journal of Community Psychology*, *35*, 463-381.

Coker, A. L., Cook-Craig, P. G., Williams, C. M., Fisher, B. S., Clear, E. R., Hegge, L. M., & Garcia, L. S. (2011). Does teaching bystanding behaviors increase bystanding and change social norms supporting violence? The University of Kentucky experience. *Violence Against Women*, *16*, 777-796.

Cook, P. G., Morris, F., & Kelly, N. (2006). *Kentucky statewide violence prevention strategic plan*. Frankfort, KY: Cabinet for Health and Family services.

Cook-Craig, P. G. (2007). *Kentucky sexual violence prevention state profile*. Frankfort: Kentucky Association of Sexual Assault Programs.

Cook-Craig, P. G. (2008). *Kentucky sexual violence primary prevention state plan*. Frankfort: Kentucky Association of Sexual Assault Programs.

Cook-Craig, P. G. (2010). Using social network theory to influence the development of state and local primary prevention capacity building teams. *Journal of Family Social Work*, *13*, 313-325.

Cook-Craig, P. G., & Ciarlantu, M. (2012). *Youth sexual violence prevention*. Harrisburg, PA: VAWnet Project, National Resource Center on Domestic Violence. Retrieved from http://www.vawnet.org/Assoc_Files_VAWnet/AR_YouthSVPrevention.pdf

Cook-Craig, P. G., Coker, A. L., Clear, E. R., Garcia, L. S., Bush, H. M., Brancato, C., et al. (2014). Challenge and opportunity in evaluating a diffusion based active bystanding prevention program: *Green Dot* in high schools. *Violence Against Women*, *20*, 1179-1202.

Cook-Craig, P. G., Lane, K., & Seibold, W. (2010). Building the capacity of states to ensure inclusion of rural communities in state and local primary violence prevention planning. *Journal of Family Social Work*, *13*, 326-342.

Cox, P. J., Keener, D., Woodward, T., & Wandersman, A. (2009). *Evaluation for improvement: A seven-step empowerment evaluation strategy for violence prevention organizations*. Atlanta, GA: Centers for Disease Control and Prevention.

Dahlberg, L. L., & Krug, E. G. (2002). Violence—A global health problem. In E. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), *World report on violence and health* (pp. 1-22). Geneva, Switzerland: World Health Organization. Retrieved from http://whqlibdoc.who.int/publications/2002/9241545615_chap1_eng.pdf

DeGue, S., Simon, T. R., Basile, K. C., Yee, S. L., Lang, K., & Spivak, H. (2012). Moving forward by looking back: Reflecting on a decade of CDC's work in sexual violence prevention, 2000-2010. *Journal of Women's Health*, *21*, 1211-1218.

Fetterman, D. M. (1996). Empowerment evaluation. In D. M. Fetterman, S. J. Kaftarian, & A. Wandersman (Eds.), *Empowerment evaluation: Knowledge and tools for self-assessment & accountability* (pp. 3-46). Thousand Oaks, CA: Sage.

Foster-Fishman, P. G., Berkowitz, S. L., Lounsbury, D. W., Jacobson, S., & Allen, N. A. (2001). Building collaborative capacity in community coalitions: A review and integrative framework. *American Journal of Community Psychology*, *29*, 241-261.

Gidycz, C. A., Layman, M. J., Rich, C. L., Crothers, M., Gylys, J., Matorin, A., et al. (2001). An evaluation of an acquaintance rape prevention program: Impact on attitudes, sexual aggression, and sexual victimization. *Journal of Interpersonal Violence*, *16*, 1120-1138.

Gidycz, C. A., Rich, C. L., Orchowski, L., King, C., & Miller, A. K. (2009). The evaluation of a sexual assault self-defense and risk reduction program for college women: A prospective study. *Psychology of Women Quarterly*, *30*, 173-186.

Haas, E. N., & Doll, L. S. (2007). *Handbook of injury and violence prevention*. New York: Springer.

Kelly, J. A. (2004). Popular opinion leaders and HIV prevention peer education: Resolving discrepant findings and implications for the development of effective community programmes. *AIDS Care*, *16*, 139-150.

Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. I., Seybolt, D., Morrissey-Kane, E., & Davino, K. (2003). What works in prevention: Principles of effective prevention programs. *American Psychologist*, *58*, 449-456.

Sabah, Y. M., & Cook, P. G. (2008). Organizational learning in social services. In T. Mizrahi & L. E. Davis (Eds.), *Encyclopedia of social work* (20th ed., pp. 327-328). Washington, DC: NASW Press.

Sabah, Y. M., & Cook-Craig, P. G. (2010). Learning teams and virtual communities of practice: Managing evidence and expertise beyond the stable state. *Research on Social Work Practice*, *20*, 435-446.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2009). *Sexual violence: Risk and protective factors*. Retrieved from http://www.cdc.gov/ViolencePrevention/sexualviolence/riskprotectivefactors.html

Wandersman, A., Snell-Johns, J., Lentz, B., Fetterman, D. M., Keener, D. C., Livet, M., et al. (2005). The principles of empowerment evaluation. In D. M. Fetterman & A. Wandersman (Eds.), *Empowerment evaluation principles in practice* (pp. 27-41). New York: Guilford Press.

Yin, L. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage.

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