

**Testimony
to the Ohio Senate, Education Committee**

**Regarding House Bill 19
School districts-dating violence policy/education
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by
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Good afternoon Chairman Cates, Ranking Minority Member Sawyer and members of the Education Committee. My name is Kenneth Steinman. I'm Clinical Assistant Professor of Health Behavior and Health Promotion at the Ohio State University College of Public Health. Also for the last three years, I've directed the Ohio Family Violence Prevention Project, an effort administered by the Health Policy Institute of Ohio. Much of my research involves using various existing data sets to describe the scope and consequences of family violence in Ohio and to use this information to inform policy decisions at the state and local level.

My testimony today aims to briefly answer two questions: (1) Is teen dating violence really a serious threat to young people in Ohio? and (2) Must we mandate school-based programs in order to develop effective prevention efforts?

As a researcher and a parent, I am concerned about many different threats to the well-being of young people in Ohio. Yet there are three criteria that can help us prioritize which health issues are most compelling to address. To be worthy of our scarce resources, a health problem must be common and consequential yet amenable to change.

Teen dating violence is remarkably common. In my written testimony, Figure 1 presents estimates for the number of 15-19 year old females in Ohio who experience different threats to their health. Conservatively, 20,000 young women experienced serious teen dating violence last year, compared to 13,407 who contracted Chlamydia (a common sexually transmitted infection), 12,000 injured in a suicide attempt and 10,000 injured in a motor vehicle accident.

Teen dating violence is also consequential. Through the stories of Ms. Tina Crouch and others, I'm sure you are already aware of the tremendous harm that teen dating violence can cause. Considerable research suggests that such violence is associated with poor academic achievement, substance use, unhealthy weight control behaviors, sexual risk behaviors, pregnancy, and suicide.

Finally, a growing number of rigorous evaluation studies suggest that school-based prevention efforts can have a demonstrable affect on curtailing teen dating violence. Most notably the *Safe Dates* program, developed in North Carolina and *Fourth R* in Ontario, Canada have produced remarkable reductions in the problem. Therefore, it is encouraging to consider that however common and consequential, teen dating violence is a problem that can be changed.

Yet just because school-based programs *can* be effective does not necessarily mean that they *will* be effective. In truth, when researchers have sought to replicate these programs they often are unable to reproduce the positive results. One thoughtful review of 10 such programs conceded that

“conclusions about the overall efficacy of dating violence interventions are premature, but such programs are promising.” (Whitaker et al., 2006, p. 151).

This, then, cuts to the heart of the matter – should Ohio mandate school-based programs on teen dating violence given the current state of prevention science? Should we require such programs statewide, confident that the benefits will outweigh the costs? Or should we wait until we better understand how and why prevention programs work?

To answer this question, it is helpful to consider other recent public health successes among teens. From 1997-2007, for example, marijuana use among Ohio high school students dropped by a quarter – from 25% to less than 18%. During this same period, cigarette use plunged by one third, 35% to 22%. We have also seen similar marked decreases in drunk driving (from 13.6% to 9.5%) and births to teenage mothers (28.8 to 19.7 per 1,000; Centers for Disease Control and Prevention, 2009a; Ohio Department of Health, 2009).

Why did these changes occur? Or, to be more specific for our purposes, can we attribute these changes to school-based prevention programs?

Drug prevention programs, for example, have been developed, studied, revised and disseminated since the 1970's. Now, after three decades, we have a much better sense of why some approaches work and others do not. In the last few years, many states now only provide funding for specific curricula with a well-established or promising record of success.

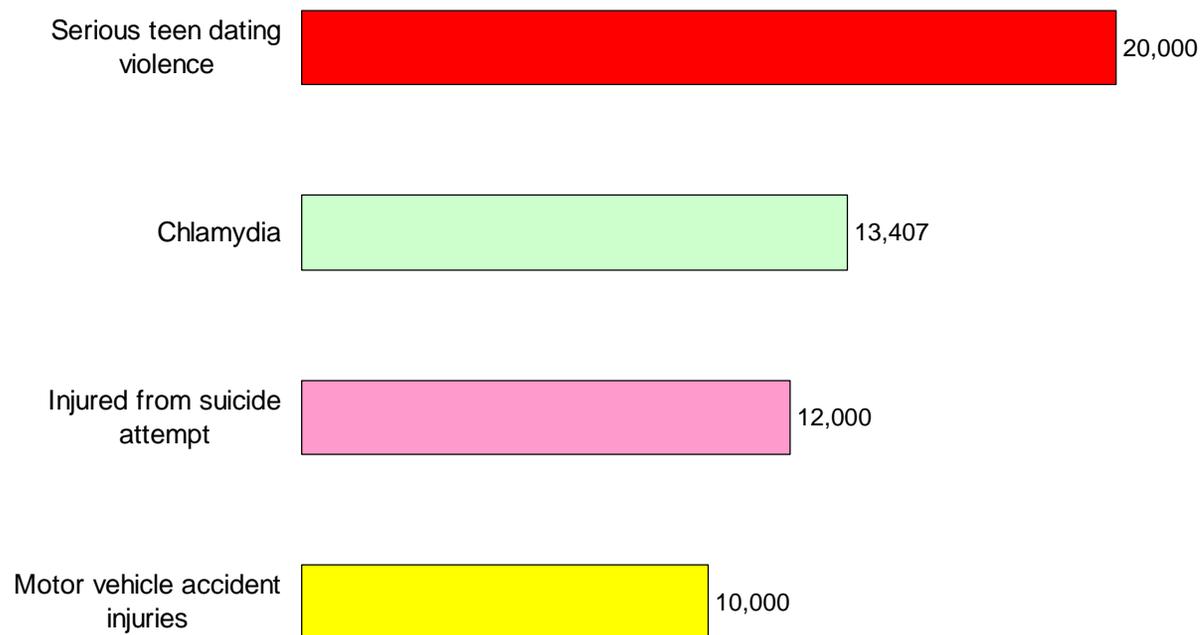
Yet we did not wait for such programs to be proven effective before we began requiring them in all schools. Rather, policy makers wisely decided that mandating such education would create opportunities for health promotion research and practice that would enable us to develop more effective programs. Without such requirements, it would have been much more difficult to develop the experience, knowledge base and effective programs we have today.

Yet even today, few schools have demonstrably effective drug prevention programs. The troubling truth is that many schools lack the resources and in some cases, motivation, to maintain and evaluate truly effective programs. It would be wrong, however, to conclude that school-based prevention has had no effect on teenage drug use. Perhaps the secret of its success lies more in its breadth than in its depth. By requiring programs in all schools, Ohio has helped initiate a broad discussion about the risks of drug use and what parents and teens can do to curtail it. Along with new policies and community efforts, school-based programs have helped changed cultural views about these risky behaviors.

Imagine if we could do the same for teen dating violence. However imperfect the actual programs, imagine if we could initiate discussions about teen dating violence in hundreds of school districts across the state. Imagine how many districts would become willing to work with agencies and universities to develop and evaluate teen dating violence programs and build a cumulative knowledge base about prevention. If dating violence is as common and consequential as other threats to teens' well being, we owe them no less.

Thank you Chairman Cates and members of the committee for allowing me to speak. I am happy to address any questions you might have.

Figure 1. Selected health outcomes among 15-19 year olds in Ohio:
Estimated # females experiencing outcome per year



Prepared by the Ohio Family Violence Prevention Project, a project of the [Health Policy Institute of Ohio](#).
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Figure 1 Sources

Serious teen dating violence (past year, extrapolated from 12-17 year olds, 2005, interpolated from national estimates):

Estimate derived from: Wolitzky-Taylor et al., (2008)

4.8% of girls and 1.1% of boys Serious dating violence was defined as experiencing one or more of the following types of violence from a dating partner (i.e., girlfriend, boyfriend, or other dating partner): physical assault, sexual assault, and drug/alcohol facilitated rape (DAFR). Physical assault was defined as experiencing an attack with or without a weapon in which the participant was badly injured or beaten up and/or being threatened with a dangerous weapon (e.g., gun, knife). Sexual assault was defined as forced anal, vaginal, and/or oral sex; forced digital penetration and/or foreign object penetration; and/or forced touching of genitalia. DAFR was defined as being the victim of unwanted sex (i.e., vaginal, anal, and/or oral penetration) while high, drunk, or passed out from drinking or taking drugs. DAFR was coded “yes” if participants took the drugs or alcohol on their own accord or if they were given the drug by the perpetrator or someone else. The DAFR module was administered only to female adolescents, whereas the physical assault and sexual assault modules were administered both to male and female participants. Published figures are 2.7% (girls) and 0.6% (boys) for 12-17 year olds. We limit estimate to 15-17 year olds, calculate single age-year-specific rates and then assume rates for 18-19 year olds are identical to rates for 17 year olds. This is likely a conservative estimate since considerable evidence suggests 18-21 year olds experience more dating violence than younger youth (Halpern et al., 2001). Other estimates for teen dating violence prevalence (both genders) range from 3.6% to 20% (see Halpern, 2001), so our estimate is at the lower range. Estimates from the Youth Risk Behavior Surveillance System (CDC, 2009a) consistently find prevalence rates of 9-10% for the percentage of students who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the 12 months before the survey.

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Motor vehicle accident injuries (# of 16-20 year old female drivers, passengers & pedestrians injured or killed by motor vehicles, 2007)

Source: Ohio Department of Public Safety. (2008). (see table 3.02) Actual estimates for 15-19 are likely lower, assuming driving is more common at age 20 than 15.

Chlamydia (15-19 year old females, 2003-5)

Source: Ohio Department of Health (2009). Mean annual # cases reported to ODH, 2003-5.

Injured from suicide attempt (extrapolated from 10-12th graders, 2007)

Survey reports of suicide attempts resulting in treatment by a doctor or nurse from 2007 YRBS estimates for Ohio, have a 2.83% mean prevalence for 10-12th grade females. Adding on one additional year that assumes a similar rate of 2.83% yields a rough incidence estimate of 18,000 15-19 year olds.

By way of comparison, 2007 nonfatal injury data tallied 417.53 cases per 100,000 nationally (CDC, 2009b). Applied to 15-19 year old females in Ohio=1,673. Also, add in 14 completed suicides among 15-19 year old females in Ohio (WISQARS fatal injury reports, CDC [2009b]; mean # cases 2004-6)

Population figures are US Census estimates of the 15-19 year old females in Ohio in 2008 from Federal-State Cooperative Program for Population Estimates. See:

<http://www.census.gov/popest/counties/asrh/files/cc-est2008-alldata-39.csv> .

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