PREVENTION INSTITUTE

A Health Equity and Multisector Approach to **Preventing Domestic Violence**

Toward Community Environments that Support Safe Relationships in California

© July 2017

www.preventioninstitute.org

FUNDING AND AUTHORSHIP

PREVENTION INSTITUTE

blue of california foundation

Blue Shield of California Foundation is an independent licensee of the Blue Shield Association

Written by Prevention Institute.
Principal authors: Lisa Fujie Parks, Casey Castaldi, Rachel Davis, Juliette Price, Alisha Somji. With contributions by Morgan Croce.

This publication was funded by the Blue Shield of California Foundation.

Prevention Institute (PI) is a focal point for primary prevention, dedicated to fostering health, safety, and equity by taking action to build resilience and to prevent problems in the first place. A national nonprofit with offices in Oakland, Los Angeles, and Washington D.C., we advance strategies, provide training and technical assistance, transform research into practice, and support collaboration across sectors to embed prevention and equity in all practices and policies. Since its founding in 1997, Prevention Institute has focused on transforming communities by advancing community prevention, health equity, injury and violence prevention, healthy eating and active living environments, health system transformation, and mental health and wellbeing.

Blue Shield of California Foundation improves the lives of all Californians, particularly the underserved, by making healthcare accessible, effective, and affordable, and by ending domestic violence. The Foundation believes all Californians can be healthy and safe and supports solutions to ensure the best possible care and services for the Californians most in need.

For further information, contact Lisa Fujie Parks: lisa@preventioninstitute.org

Suggested Citation

Prevention Institute. (2017). *A Health Equity and Multisector Approach to Preventing Domestic Violence*. Oakland, CA: Author.

TABLE OF CONTENTS

Acknowledgments **IV**

Introduction & Methods **1**

Safety for All: A Health Equity Approach to Understanding DV and DV Inequities **3**
Bringing Together Public Health and Social Justice Frameworks: Health Equity and Intersectionality 4
Taking Two Steps to Preventing DV 5
Starting With Injury and Illness – DV and DV Inequities 5
Take A Step: From Injury and Illness to Exposures and Behaviors 7
Take A Second Step: From Exposures and Behaviors to the Environment 8
Survivor Measures of Success Align with Changing Community Conditions for Prevention 22

Coming Together: A Multisector Approach to Fostering Community Environments that Support Safe Relationships **27**
Community Settings and Sectors: Collaboration Multiplier Analysis, Part I 27
Where We Live – Housing/Community Development and Planning/Zoning Sectors 32
Where We Work – Business and Workforce Development Sectors 36
Where We Connect and Play – Sports/Entertainment and Faith Sectors 40
Where We Receive Care – Healthcare and Social Services Sectors 42
Where We Find Support and Leadership On DV – DV Services Sector 47
Where We Find Leadership on Health and Safety – Public Health Sector 50
Addressing the Community Determinants of Multiple Forms of Violence 53
Multisector Strategies for DV Prevention: Collaboration Multiplier Analysis, Part II 54
Transforming the Physical/Built Environment while Increasing Social Networks and Trust in Newport, Rhode Island 57

Moving Forward: Toward a Health Equity and Multisector Approach to Preventing DV in California **58**
Summary Of Findings 58
The Elements to Advance a Health Equity and Multisector Approach to DV Prevention 61
Immediate Next Steps 64

Appendices & References **65**

ACKNOWLEDGEMENTS

Prevention Institute greatly appreciates the advocates, practitioners, and researchers who explored opportunities to advance a health equity and multisector approach to preventing domestic violence, and who shared their expertise and insights to inform this paper:

Beth Altshuler, Raimi + Associates

Margaret Aumann, California WIC Association

Emily Austin, Peace Over Violence

Nancy Bagnato, California Department of Public Health

Paul Bancroft, Tahoe SAFE Alliance

Karen Ben-Moshe, California Department of Public Health

Enrica Bertoldo, California Department of Public Health

Ted Bunch, A Call to Men

Jenya Cassidy, California Work and Family Coalition

Noel Duckworth, Delaware Coalition Against Domestic Violence

Karen Farley, California WIC Association

Lisa Hoffman, Consultant

Lisa James, Futures Without Violence

Casey Keene, National Resource Center on Domestic Violence

Lisa Kim, Futures Without Violence

David Lee, California Coalition Against Sexual Assault

Devorah Levine, Contra Costa Alliance to End Abuse (formerly Zero Tolerance for Domestic Violence)

Jacquie Marroquin, California Partnership to End Domestic Violence

Anna Melbin, Full Frame Initiative

Elizabeth Miller, Children's Hospital of Pittsburg

Jackie Payne, Move to End Violence

Ana Polanco, Advisor to Futures Without Violence

Kirsten Rambo, formerly with Centers for Disease Control and Prevention

Shamus Roller, formerly with Housing California

Emily Rothman, Boston University

Linda Seabrook, Futures Without Violence

Kaile Shilling, formerly with Violence Prevention Coalition of Greater Los Angeles

Nan Stoops, Washington State Coalition Against Domestic Violence

Jessica Walsh, Women's Resource Center of Rhode Island

Colleen Yeakle, Indiana Coalition Against Domestic Violence

Jonathan Yglesias, National Resource Center on Domestic Violence

INTRODUCTION

As awareness of domestic violence (DV) and concern about its impact has grown, more survivors, advocates, policymakers, families, and others are asking why DV continues to be so prevalent and what more can be done to prevent it.* And as awareness of disparities in rates of DV – by age, race, sex, socioeconomic status, and other factors – has increased, so has the desire to understand and address those inequities. The vision for addressing DV in California continues to expand toward addressing the needs of DV survivors who are most marginalized and the communities in which they live, in a manner that supports both healing from and prevention of DV.

Within this context, the Blue Shield of California Foundation supported Prevention Institute to conduct a preliminary landscape scan to inform and strengthen a statewide approach to preventing DV in California. Drawing on the literature base, the expertise and insights of over 30 key informants, and analysis conducted using several Prevention Institute tools and frameworks, *A Health Equity and Multisector Approach to Preventing Domestic Violence* presents four key findings to advance DV prevention:

1. A health equity approach is a necessary and promising path forward for advancing DV prevention in California that is well aligned with the DV services sector's** commitment to social justice.
2. The environment directly influences whether or not DV will occur, and the community environment represents an important, actionable place to promote safe relationships*** and a reduction in DV.
3. Multiple sectors have important roles to play in preventing DV, and there is emerging readiness for this approach.
4. There are particularly ripe opportunities to engage the healthcare, housing, and community development sectors in DV prevention, in partnership with other sectors.

This paper offers research, analysis, and frameworks to understand the factors in the community environment that support safe relationships and a reduction in DV. It identifies opportunities for 13 sectors to engage in DV prevention, and offers a method for multiple sectors to identify joint strengths, strategies, and outcomes. As a whole, the paper presents an overarching approach to advancing a health equity and multisector approach to DV prevention in California, and identifies broad elements and immediate next steps to move this approach forward.

A health equity and multisector approach is being applied to address numerous health and safety issues in California and across the nation with demonstrated success. This paper asserts that this approach can be applied to DV prevention in California, and offers the research, analysis, frameworks, elements, and next steps to realize this opportunity. By working together with an unwavering commitment to health equity across sectors and across communities, it is possible to promote community environments that support safe relationships, and to decrease rates of DV and inequities in rates of DV in California.

* *While California has efforts focused on the prevention of adolescent dating abuse, there has been less recent attention and analysis on the prevention of adult DV. This paper focuses on prevention of adult DV.*

** *The DV services sector refers to the diverse group of service agencies and other types of organizations that provide a variety of comprehensive supports to survivors of DV and their families, advocate for policy changes, and build reciprocal expertise to strengthen DV intervention and prevention in California. DV services can include housing assistance and shelters, emergency planning, employment assistance, public benefit assistance, prevention programs, and more.*

*** *The phrase "safe relationships" is used in this paper to describe relationships in which violence and abuse do not occur.*

METHODS

The methods used in the development of this paper and approach included reviewing the literature base, soliciting the expertise and insights of key stakeholders, including practitioners and researchers, and applying several Prevention Institute tools and frameworks. These methods were used to address the following key questions:

- What are the factors in the environment that contribute to DV and inequities in rates of DV?
- Which sectors in California can most effectively change the factors in the environment that contribute to DV and inequities in rates of DV?
- What are the opportunities for these sectors to play a role in preventing DV?
- Which sector(s) is the DV services sector most ready and interested in engaging as new or more robust partners in DV prevention?

To answer the key questions, Prevention Institute:

1. Reviewed relevant documents, reports, and literature and conducted interviews with 31 advocates, practitioners, and researchers from diverse fields and sectors to identify the factors (structural drivers, community determinants, and overarching community factors) that are associated with DV and inequities in rates of DV, as well as those that are associated with safe relationships and a reduction in DV;
2. Organized findings using Prevention Institute models/frameworks, including Two Steps to Prevention and THRIVE (Tool for Health and Resilience in Vulnerable Environments);
3. Identified 13 key sectors that can significantly influence the factors in the community environment associated with DV;
4. Conducted preliminary analysis using Prevention Institute's Collaboration Multiplier tool to identify potential opportunities for the 13 key sectors to influence community determinants to prevent DV, and explore how multisector efforts across two or more sectors could enhance outcomes;
5. Explored the DV services sector's investment and readiness to engage new sectors as new or more robust partners in DV prevention, and unique leadership and bridge-building role;
6. Engaged in synthesis and analysis, and developed a summary of findings;
7. Described the elements that are needed to advance a health equity and multisector approach to DV prevention in California; and,
8. Identified immediate next steps.

Safety for All

A Health Equity Approach to Understanding Domestic Violence and Inequities in Rates of DV

In order to develop a statewide approach to preventing DV in California, it's important to first understand the extent and nature of the problem of DV. While DV occurs in all communities, research shows that specific communities have disproportionately higher rates. In order to prevent DV across communities and achieve significant reductions across the State, disparities in rates of DV must be understood and addressed. Inequities in rates of DV, like other inequities in health and safety, refer to differences that are unnecessary and avoidable but, and in addition, are considered unfair and unjust. Inequities in DV and other health inequities are related both to historic and present day practices and policies of public and private institutions that result in diminished opportunity for certain populations.[1] A health equity approach seeks to understand, and then to address, the factors that contribute to unnecessary, avoidable, unfair, and unjust inequities, and to promote "an equal opportunity to achieve optimal health."[2] In the context of DV, this means that understanding and promoting the conditions that allow everyone to have an equal opportunity to be safe in their relationships, homes, and communities. Prevention Institute's Two Steps to Prevention tool and THRIVE (Tool for Health and Resilience in Vulnerable Environments) framework were used to develop an understanding of the extent and nature of DV and DV inequities in California, and to identify the conditions that could ensure equitable access to safety.

Bringing Together Public Health and Social Justice Frameworks: Health Equity and Intersectionality

The movement against DV has strong ties to social justice frameworks and growing influence from intersectionality theory. Coined by Kimberlé Crenshaw to reflect the scholarship and experiences of women of color feminists in the 1980s,[3] intersectionality theory "describes the ways in which power structures based on race, ethnicity, gender, class, ability, religion, nationality/citizenship, and other markers of difference interact to inform individual realities and lived experiences, as well as to shape systemic policies and practices."[4] DV advocates are increasingly concerned with how gender oppression intersects with other processes of oppression and multiple social positions such as race, class, sexuality, and disability. Embracing the complexities of intersecting systems of oppression, the field is focusing on ways to work with social movement leaders and organizations to create transformative change. For example, advocates addressing DV are reaching out to immigrant rights movements to better understand and address the needs of immigrant survivors and to form partnerships that foster healing, safety, and social change.

The concepts and approaches presented in this paper are rooted in a public health and health equity perspective. While there are relevant distinctions, a health equity approach aligns well with the DV movement's commitment to and momentum toward intersectionality. DV advocates can find a health equity approach useful in their efforts to prevent DV, as this approach counters the unequal and unjust conditions that lead to violence and inequities in violence, and aims to ensure that every person has an equal opportunity to achieve optimal health and safety.[5,6] Although public health has had a greater focus on inequities by race and class, there is growing acknowledgement of the need for more attention to addressing gender inequity as well.[7] Considerations of intersectionality can help public health derive a more precise identification of inequities and their causes.[8]

"Prevention requires us to look at what is behind problems to identify the specific behaviors and the risk and protective factors associated with them. In primary prevention we then go further by asking what conditions in the environment contribute to and shape those behaviors."

– David Lee, California Coalition Against Sexual Assault1 [9]

Taking Two Steps To Preventing DV

The environment in which we live has a tremendous impact on health and safety. A Prevention Institute tool, Two Steps to Prevention, helps to convey that impact. The tool was developed to analyze the underlying causes of illness and injury and inequities in illness and injury, and to identify the key opportunities for prevention. Two Steps to Prevention presents a systematic way of first looking at injury and illness, then at the exposures and behaviors that affect these outcomes, and then at the environment that shapes patterns of exposure and behavior or directly influences the onset of injury and illness. Prevention Institute applied this methodology to identify the key elements in the environment associated with DV and with safe relationships. The public health approach underscores the importance of not only addressing factors that increase risk, but also of strengthening factors that build resilience, and as such, both sets of factors within the environment were examined.

Starting With Injury and Illness – DV and DV Inequities

According to the 2009 California Health Interview Survey, approximately 14.8% of adults reported experiencing DV since age 18.[10] In total, 3.5 million Californians experienced DV as an adult, which is comparable to the population of Los Angeles – the most populous city in California.[11] The same survey found women are two times more likely to be victimized compared to men (20.5% of women vs. 9.1% of men). Nationally data also show that DV is rampant: according to the 2011 National Intimate Partner and Sexual Violence Survey (NISVS), around one-third of women and a quarter of men report having experienced rape, physical violence and/ or stalking by an intimate partner in their lifetime.[12] DV occurs across gender and racial/ethnic lines, but occurrence varies by several factors:

- Women ages 18 to 24 and 25 to 34 generally experienced the highest rates of intimate partner violence.[13]
- Women ages 20-24 are at greatest risk of nonfatal domestic violence.[14]
- DV is typically more common among women and men of color compared to white women and men, with women of color experiencing significantly higher rates overall.[15]

- African American women face higher rates of domestic violence than white women,[16] and Native American women are victimized at a rate that exceeds those experienced by women of other races.[17]
- In California, the 2009 Health Interview Survey data shows that American Indian/Alaskan Native women are 1.8 times more likely to experience DV in their lifetime.[18]
- The likelihood of multiracial non-Hispanic women experiencing DV is 1.6 times greater than for white women.[19]
- Women of two of more races and African American women have higher rates compared to white women in California (1.4 and 1.2 times more likely than white women, respectively).[20]
- Women living in households with lower annual incomes experience the highest average annual rates of intimate partner violence.[21]
- Rates from the 2010 NISVS found 43.8% of lesbian women and 61.1% bisexual women reported experiencing DV, compared to 35% of heterosexual women.
- Rates among gay and heterosexual men are similar (26% and 29%, respectively), but bisexual men face an increased risk (37.3%).[22]
- In California, bisexual, gay, and lesbian adults are close to two times more likely to be victimized. Similar to national DV rates, bisexual Californian adults also face the highest risk compared to other sexual orientations surveyed.[23]

It is important to note that DV is typically underreported due to stigma and fear of retaliation and available data tend to focus on female identified victims and male identified perpetrators. Current data do not account for the full racial, ethnic, sexual, gender and relationship diversity within communities and are almost exclusively criminal justice or services data. However, available information points to disparities in rates of DV and correspond with inequities based on race, sex, socioeconomic status, sexual orientation, gender identity, and other factors.

Diagram 1: Exposures and Behaviors Related to DV and DV Inequities

Take A Step: From Injury and Illness to Exposures and Behaviors

The first step of the Two Steps to Prevention analysis is from examining an injury or illness to identifying exposures and behaviors that contribute to injury and illness. Limiting unhealthy exposures and behaviors enhances health and safety and reduces the likelihood and severity of poor health and safety outcomes. Through literature review and interviews, Prevention Institute identified a number of exposures and behaviors associated with DV, including: history of witnessing violence; adherence to norms related to gender inequities, violence and non-intervention; awareness of lack of community sanctions against DV; and, desire for power and control in relationships.[24 25]

"It's not just the individual, it's the dynamics in the community that create the very things that make it easy and okay for a person to abuse another. We need to move the focus from the individual, stop victim blaming, and look more at what society needs to do to be more transformative in our approach – to take the entire individual, family and community into account. This means that community does not ignore its own role in the dynamic, and that all members benefit."

– Rabeya Sen, Esperanza Community Housing Corporation[26]

Take A Second Step: From Exposures and Behaviors to the Environment

The second step of the Two Steps to Prevention analysis is from understanding the exposures and behaviors to understanding the role of the environment in shaping exposures and behaviors, as well as health and safety outcomes. Our collective knowledge of how the environment influences health, safety, and inequities has deepened significantly over the past decade. The environment includes structural drivers and community determinants.*

The Determinants of DV and DV Inequities

Structural Drivers

In analyzing the social determinants of health and health inequities, the World Health Organization (WHO) has identified structural drivers—the inequitable distribution of power, money, opportunity and resources—as a key determinant of inequity in health and safety outcomes.[27] At a fundamental level, inequity in health outcomes can be understood as a disparity in power. Groups with less power tend to suffer worse health outcomes.

Community Determinants Associated with DV

Another way that structural drivers influence health outcomes is by shaping the circumstances in which people are born, and grow, live, work, and age. The WHO also identified community environments as a key contributor to inequity in health outcomes.[28] Drivers such as structural racism and socio-economic inequity, for example, play out at the community level to deeply impact community conditions. Research has now shown that after adjusting for individual risk factors, there are neighborhood differences in health and safety outcomes.[29] Thus, community environments fundamentally impact health, safety, and inequity, and represent an important, actionable place to promote equity in health and safety outcomes.

To understand the community determinants of DV and DV inequities, Prevention Institute conducted a scan of the body of available research on community-level risk factors associated with DV and

* *The term "community determinants" comes from the World Health Organizations' Social Determinants of Health which are largely understood as the broad set of factors that influence health outcomes directly and that shape community environments. Social determinants of health include structural drivers (e.g., the inequitable distribution of power, money, opportunity, and resources) and conditions of daily life (e.g., the community environments in which people are born, live, work, play, worship, and age). In the context of this report, "community determinants" refers to the conditions of daily life. This term is also comparable to the terms community-level factors and community conditions, which are commonly used by the Center for Disease Control and Prevention.*

"Lack of affordable and safe housing, transience, lack of employment, social norms based in a partying culture, and denial that social ills can happen in our postcard rural community all contribute to DV."

– Paul Bancroft, Tahoe SAFE Alliance[30]

community-level resilience factors associated with safe relationships.* Through interviews, advocates, practitioners, and researchers were also asked about their understanding of the community determinants associated with DV and with safe relationships.

Six community determinants have evidence of association with DV: harmful norms and culture; weak social networks and trust; weak community sanctions against DV; harmful media and marketing practices; housing insecurity; and, economic insecurity.

Findings from the literature and interviews aligned well with Prevention Institute's THRIVE (Tool for Health and Resilience in Vulnerable Environments) framework. THRIVE is a community resilience framework for understanding: 1) how structural drivers play out at the community-level, impacting daily living conditions and, consequently, community outcomes for health, safety, and health equity; and, 2) how community change can push back against these structural drivers.[31] THRIVE identifies 12 community determinants of health and safety, grouped in three interrelated clusters: the socio-cultural environment (people), the physical/built environment (place), and the economic/educational environment (equitable opportunity).

THRIVE was created through an iterative process of scanning peer-reviewed literature, reports and interviews with practitioners and academics starting in 2002, and was updated in 2011-2012 based on a review of social determinants of health literature.[32] The language of THRIVE was developed by piloting and gaining feedback from communities with the goal of incorporating "community friendly" terms rather than research/academic language. While this report was informed by the available research, we chose to largely use the language found in the THRIVE framework to make the concepts more accessible to a larger audience.

Applying Prevention Institute's THRIVE framework, the six community determinants for which there is evidence of association with DV were organized into THRIVE's three interrelated clusters: people, place, and equitable opportunity. No one determinant alone can be attributed

* *The majority of the research cited in this paper was conducted at the community or population level and reflect risk of DV occurrence in a community. However some research cited was conducted at the individual level, through surveys of individuals (e.g. surveys asking people about their neighborhood's support and cohesion) and thus indicate risk of perpetration or victimization. In the absence of population level studies, such results may be considered proxies for community-level risk and resilience factors. While our scan was extensive, the list of determinants is not an exhaustive catalogue of community-level factors. The determinants were chosen based on strength of evidence in the academic and grey literature and recommendations from advocates, practitioners, and researchers. Lack of evidence supporting a link between a particular factor and DV does not necessarily mean that a connection does not exist, but rather that research was not found that demonstrates such a connection.*

"Domestic violence is the manifestation of sexism. It is born out of the way men think about being men, how men are taught to view women, and how men then pass that teaching down to our boys."

– Ted Bunch, A Call to Men[33]

with causing or preventing DV; it is the accumulation of the community determinants of DV without compensatory community determinants of safe relationships that increase risk. The six community determinants are interrelated and influence each other. For example, housing insecurity can diminish social networks and trust, which can contribute to harmful norms and culture.

People Cluster

1. **Harmful norms and culture** are the broadly accepted behaviors to which people generally conform that implicitly or explicitly condone inflicting emotional or physical distress on others and reward behaviors that negatively affect others.[34] Our research indicates that harmful norms and culture is relevant to DV in several different ways:

   a. Norms that support gender inequities in relationships are associated with higher levels of DV.[35 36 37] These norms are also referred to in the literature as male dominance norms,[38] traditional gender roles,[39] beliefs in male superiority and entitlement,[40] and masculine gender role ideologies.[41] Male dominance norms play out in intimate relationships, for example, through expectations that women should stay at home and be submissive to a male partner, and men should provide financially for the family and make household decisions.[42 43] Such norms reinforce limits on women's decision-making power, and increase acceptance of violence in intimate relationships.[44] Gender inequitable norms related to economic and decision-making power in relationships are particularly associated with DV. For example, a study of 90 different societies found that physical DV against women is perpetrated more frequently in societies in which men have greater economic and decision-making power in the household.[45]

   b. Norms supportive of violence, which implicitly condone the use of violence as a means to assert dominance and address conflict are also associated with higher rates of DV.[46 47] DV is more common in societies that condone the use of violence as a means to resolve conflict.[48 49]

   c. Norms of non-intervention in family matters, refers to expectations that DV should be understood and treated as a private family matter for which it is inappropriate to intervene even when one has witnessed or is aware of DV. Researchers have found a

consistent and significant relationship between the percent of community respondents in agreement with non-intervention norms (such as the statement "fighting between friends or within the family is nobody else's business") and physical DV.[50] In the context of norms supportive of gender inequities in relationships and norms supportive of violence, norms of privacy and non-intervention both enable and reinforce the use of violence in intimate relationships.

2. **Weak social networks and trust** is the lack of trusting relationships among community members and the lack of opportunities to exchange information and create new, strong social networks.[51] Research shows an association between ***distrust*** (i.e., low levels of sense of community, cohesion, trust, and reciprocity) and DV.[52] [53] As well, ***social isolation,*** which confines residents and restricts the creation of social networks in communities, is a risk factor for DV victimization.[54] [55] [56] Communities that face structural drivers of inequities, including structural racism, socio-economic inequality, suffer from weakened social networks and trust. Within communities with weak social networks and trust, LGBTQI individuals often face additional levels of distrust and social isolation as a result of systemic anti-LGBTQI discrimination.

3. **Low participation and low willingness to act for the common good** is the general lack of capacity, desire and ability to participate, communicate and work to improve the community; lack of opportunities for meaningful participation by local/indigenous leadership; and a lack of opportunities for community involvement such as through local community and social organizations and participation in the political process.[57] In the context of DV, these low levels of participation and willingness to act manifest themselves as ***weak community sanctions against DV***, which reflect a lack of collective accountability for and an implicit enabling of violence in intimate relationships, and are associated with increased rates of DV.[58] [59] Community sanctions refer to both legal sanctions as well as moral and social pressure from the broader community to intervene to address and prevent DV.[60] In the context of norms supportive of gender inequities in relationships and norms supportive of violence, weak community sanctions both enable and reinforce the use of violence in intimate relationships.

"Intimate partner sexual assault is in part a spillover of media that portray women being objectified, humiliated, punished, and enjoying it."

– Emily Rothman, Boston University[61]

Place Cluster

4. **What's sold and how it's promoted, i.e., harmful media and ways of promoting products** can be seen within a community in the concentration of harmful media and harmful marketing practices.[62] In the context of DV, this plays out in several specific ways.

   a. Media and marketing practices that reinforce harmful norms and culture are associated with DV. Media products such as pornography and violent video games may play a role in creating environments conducive to DV through content and marketing that propagate harmful gender norms and normalize violence. Frequent pornography use has been linked to increased sexual aggression[63 64 65] and playing violent video games may increase risk of aggression and perpetrating violence.[66] With the belief that "sex sells," the prevalence of violence against women and depictions of sexual aggression have been common in advertising since the 1980's.[67] In one example, an alcohol ad densely marketed in one community commodified female Latinas and was linked to sexual victimization of females in that community.[68]

   b. High alcohol outlet density and availability refers to the quantity and geographic distribution of establishments including bars/pubs, restaurants and liquor stores that sell and market alcoholic products within a specific geographic area or neighborhood.[69 70] High alcohol outlet density and availability is seen in communities of color with low average household incomes as a result of deliberate policies and practices. For example, in the 1980's the Small Business Administration encouraged liquor store ownership among entrepreneurs of color with little capital because minimal capital was required for business startup. This fueled the density of alcohol outlets in communities of color with low average household incomes that still exists today.[71] At the community-level, alcohol outlet density affects individual alcohol use, as well as delinquent behavior, and has been associated with higher reported incidence of DV.[72 73 74] For example, an ecological study of alcohol outlet density in Sacramento, California found that at the neighborhood level, each additional off-premise alcohol outlet was associated with approximately a 4% increase in DV related police calls and a 3% increase in DV related crime reports.[75] Further, a population-level survey of US couples found a 34% increase in male-to-female partner violence with an increase of 10 alcohol outlets per 10,00 persons.[76] While DV cannot be attributed to alcohol availability and/or use alone, a well-established link exists between heavy alcohol use and

perpetration of DV.[77] The WHO describes alcohol intoxication as an important factor that interacts with other determinants in certain situations to precipitate use of violence.[78]

5. **Housing insecurity**, which can include a lack of high-quality, safe and affordable housing, difficulty paying rent, mortgage or utility bills, frequent moves, and overcrowded living conditions – is associated with DV.[79] The CDC National Intimate Partner and Sexual Violence Survey found that women who experienced housing insecurity had a significantly higher prevalence of DV during the prior 12 months than those who did not experience housing insecurity.[80] Similarly, in a study of California women, researchers found that after adjusting for other factors, women who experienced DV in the last year had approximately 4 times the odds of reporting housing insecurity than women did not experience DV.[81] DV can contribute to housing insecurity, as someone experiencing DV may need to leave their current housing to seek safety. Housing insecurity and DV both increase the risk for homelessness. The 2010 Federal Strategic Plan to End Homelessness cites "among mothers with children experiencing homelessness, more than 80% had previously experienced domestic violence." [82]

Without access to safe and affordable housing, families may live in housing that is unsafe and overcrowded with persistent fear of loss of stability, which may create a highly stressful situation that makes it difficult for people to regulate emotions and practice non-violent social skills to maintain safe relationships.[83] The conditions surrounding the housing environment also effect risk for DV. For example, there are higher rates of DV in neighborhoods with "physical incivilities," e.g., high levels of trash, compared to areas with better trash management.[84]

There are interrelationships between housing conditions and other community determinants. For example, housing environments that lack open space, green space, and places to connect socially may contribute to weakened social networks and trust. Policies and practices such as mass incarceration as well as exclusionary practices within Housing Authorities that bar people with felony convictions from accessing public housing have also contributed the breakdown of social and family networks. Lack of strong social networks and trust can contribute to perceptions of lack of safety, and reinforce norms of non-intervention within family matters within communities.[85]

"Poverty and economic insecurity are key. But it's not just poverty — poverty doesn't cause DV. The social and economic isolation that comes with poverty gives rise to systematic lack of opportunity and access to resources, and the resultant marginalization contributes to a number of ills in a community, sometimes including DV."

– Anna Melbin, Full Frame Initiative[86]

When people perceive their housing environment to be undesirable, unsafe and are concerned for their own safety, and do not have strong social networks and trust, they are less likely to take action to address DV, thus contributing to weak community sanctions against DV.[87]

*Equitable Opportunity Cluster**

6. **Lack of living wages and local wealth** are characterized by a lack of local ownership of assets; the inaccessibility of local employment that pay living wages and salaries; and the lack of access to investment opportunities.[88] As it relates to DV, this lack of living wages and local wealth is referred to as ***family and community economic insecurity***.[89] Family and community economic insecurity, as it is associated with DV, can be characterized in a number of different ways, including high unemployment rates,[90] concentrated poverty,[91] and neighborhood disadvantage.[92] Although DV occurs in relationships across socio-economic factors, strong evidence indicates that the risk is greater in communities with higher neighborhood poverty and unemployment.[93 94] Researchers hypothesize that: first, concentrated socio-economic disadvantage leaves families and entire communities deprived of economic resources to meet basic needs and increases levels of family and community stress, conflict, and instability, which in turn increase the likelihood of DV; and second, that concentrated socio-economic disadvantage contributes to low social capital and weak community sanctions against DV.[95] Whatever the precise mechanisms, family and community economic insecurity likely acts as an indicator for a variety of factors that combine to increase the risk of DV.[96]

* *According to the CDC, low academic achievement has been established as a risk factor for DV victimization and perpetration at the individual level and thus educational opportunity may impact the likelihood of violence in a community. However, research findings on the influence of education on DV prevalence at the community or neighborhood level have been mixed. While education is clearly linked to poverty and economic insecurity, which is associated with DV, according to Beyer, Wallis, and Hamberger's systematic review of research in U.S. settings (2015), the relationship between educational attainment and DV prevalence may not be significant at the community-level when economic factors are controlled for. Therefore, education is not included as a community determinant in this paper.*

"When you put the most marginalized folks in the center of the process and really engage those folks, people start to realize the connections between things like economic justice, immigration reform, etc. Then it becomes clear that it's necessary to dismantle the ways that systems create disparities."

– Jackie Payne, Move to End Violence[97]

Overarching Community Factors: Community Violence and Community Trauma

Community violence is intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim, and is characterized by its shared collective impact and cyclical nature within the community.[98] Exposure to community violence and the subsequent trauma is also associated with many factors that increase risk of DV, such as family and community economic insecurity, and is associated with an increased risk of future violence, including DV.[99 100 101 102 103]

Community trauma is the cumulative and synergistic impact of interpersonal violence, historical and intergenerational violence, and exposure to the impact of structural drivers of inequity. Community trauma is not just the aggregate of individuals in a neighborhood who have experienced trauma from exposures to violence. There are manifestations, or symptoms, of community trauma at the community level.[104] Community trauma affects multiple generations and can increase risk of DV within a community. For example, in the U.S., the destruction of Native American culture, families, traditions and lives at the hands of European settlers resulted not only in individual trauma, but in the communal traumatization of entire Native American societies. The impact of these drastic changes to family structures and power dynamics within relationships has led to multigenerational community trauma. According to Oetzel and Duran (2004), these changes contributed to increased rates of DV within a culture where it was previously almost non-existent.[105]

For many communities (primarily communities of color with low average household incomes) and for LGBTQI individuals within those communities, decades of disinvestment, structural racism, and violence have led to disproportionately higher levels of community violence and community trauma. While community determinants associated with DV, along with community violence and community trauma, are found in communities across the country, the results of their interactions are most rampant and negatively reinforcing in communities of color with low average household incomes and among LGBTQI individuals. Community violence and community trauma are not only products of structural drivers playing out within the community environment, but also alter community environments and determinants, reinforcing community and family systems and cycles of disenfranchisement, inequity, and multiple forms of violence. Due to this interplay, community violence and community trauma can be understood as overarching community factors shaping the prevalence of DV and DV inequities.

Diagram 2: The Environment Associated with DV and DV Inequities

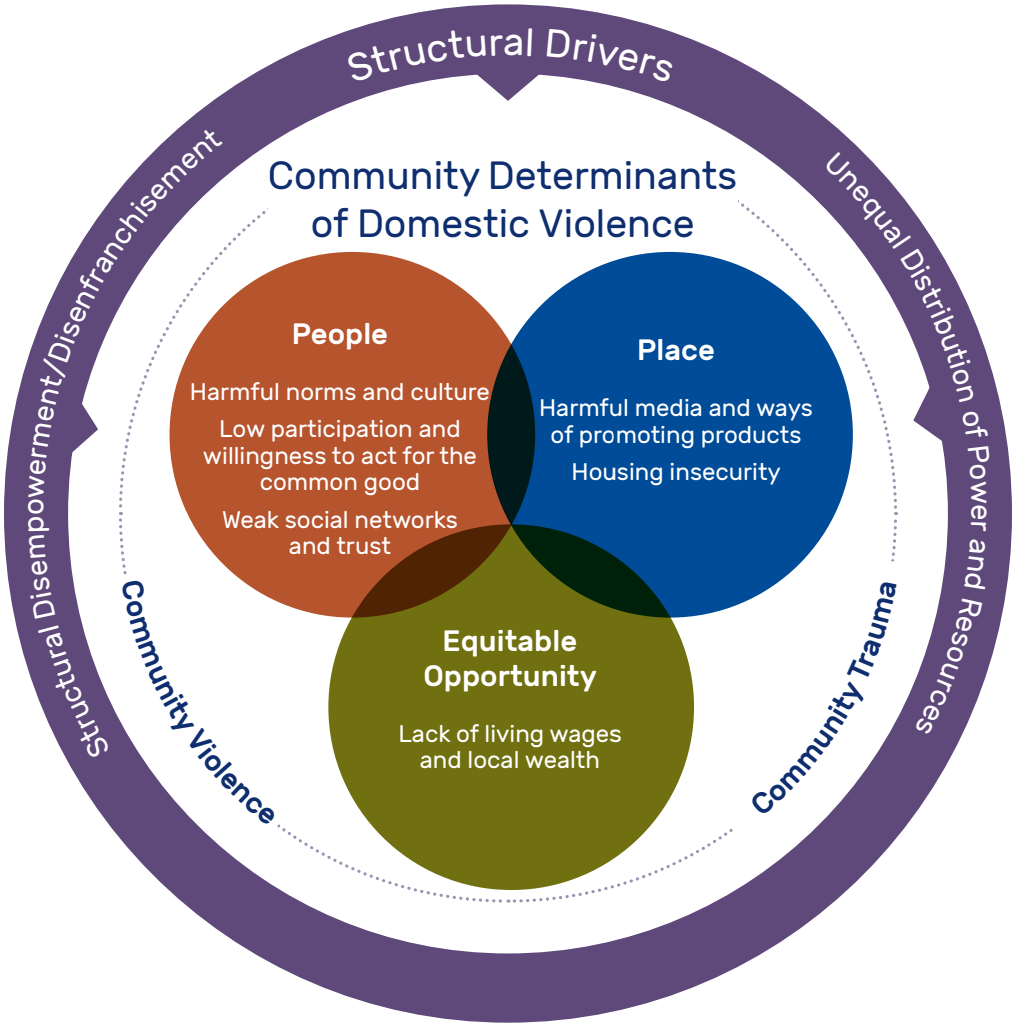


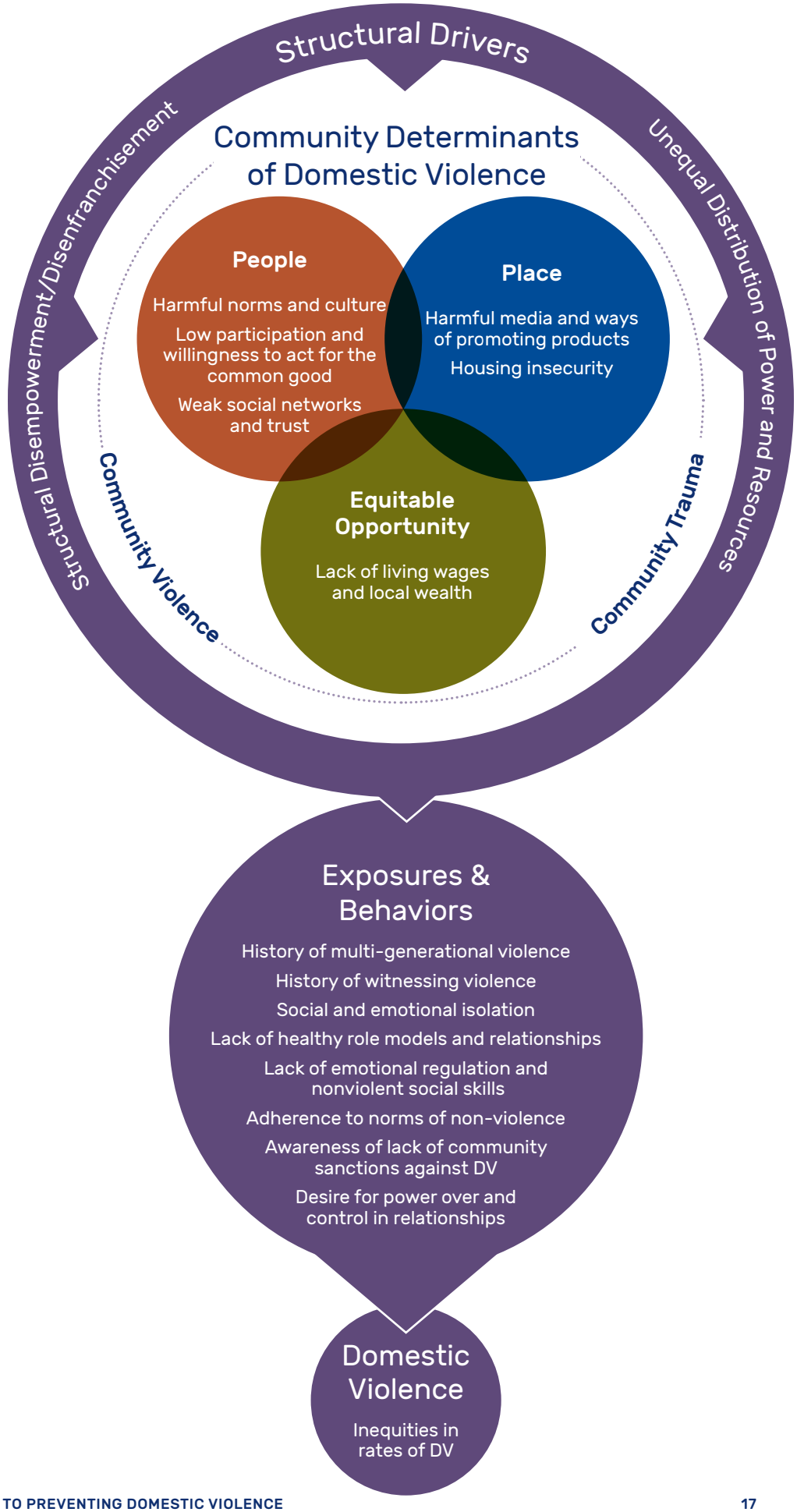
Diagram 2 shows the environment associated with DV and DV inequities, including structural drivers, community determinants, and overarching factors.

The Trajectory of DV and DV inequities

Another way to understand Two Steps to Prevention is to examine Prevention Institute's trajectories of health inequity and health equity, as they apply to DV. Diagram 3, the Trajectory of DV and DV Inequities, shows the relationships between: structural drivers; the community determinants of DV; exposures and behaviors; and DV and inequities in DV. The trajectory illustrates how DV and inequities in DV perpetration and victimization are produced along a pathway from structural drivers to community determinants, which contribute to and are exacerbated by exposures and behaviors – all of which contribute to inequity in the rates of DV perpetration and victimization.

Diagram 3: The Trajectory of DV and DV Inequities

The trajectory illustrates visually how the continuous and reciprocal interplay of factors within the environment (structural drivers, the community environment, community determinants, and overarching community factors) fundamentally shape exposures and behaviors, and thus contributes to DV and inequities in DV. The diminishing size of the circles from top to bottom indicates a diminishing contribution to perpetration and victimization. The trajectory demonstrates that structural drivers and community determinants have the most significant impact on DV and DV inequities. The trajectory is not a linear model and is not predictive, nor does it suggest causality. Rather, it depicts the complexity of interrelated factors that contribute to DV and DV inequities.



"Focusing on multiple factors is easier said than done. But there is a danger in focusing just on one factor, like social cohesion. Is the association between the factor and DV strong enough? Focusing on social cohesion, and housing policies, and immigration policies might be a quicker route to making people safer."

– Emily Rothman, Boston University[106]

The Determinants of Safe Relationships and Reduced DV

Structural Drivers

The positive conceptualization of the structural drivers identified by the WHO are: structural empowerment/enfranchisement and the equitable distribution of power and resources. These structural drivers of health equity can fundamentally promote positive health and safety outcomes and equity in those outcomes.

Community Determinants Associated with Safe Relationships and Reduced DV

Though research on resilience factors, particularly at the community level, is quite limited, there are a number of interrelated factors for which there is emerging evidence of association with safe relationships and a reduction in DV. The determinants of safe relationships included below draw on the available research, including research on community resilience, as well as extrapolation from the determinants of DV. The six factors identified in the literature cluster into the THRIVE interrelated community environments: people, place, and equitable opportunity.

People Cluster

1. **Healthy norms and culture** are defined as broadly accepted behaviors to which people generally conform that promote health, wellness and safety among all community residents; discourage behaviors that inflict emotional or physical distress on others; and reward behaviors that positively affect others.[107] These norms play out within safe relationships in several specific ways:

   a. Norms that support healthy and equitable relationships such as the belief in non-violent conflict resolution, the belief in a partner's right to autonomy, shared decision-making, and equitable gender norms and roles are supportive of safe relationships.[108] These norms are likely to lead to more equitable relationships characterized by mutual respect and non-violent conflict resolution.[109]

   b. Norms that support non-violence, including attitudes, beliefs, and behaviors consistent with the use of non-violent means to resolve conflict and effective communication skills are associated with safe relationships.[110] [111]

   c. Norms that support engagement in family matters refers to expectations that community members should engage in matters related to safe relationships in families, for example, the expectation that one would intervene to offer social and emotional support to families, especially in times of need.

"Social cohesion and inclusion are preventative and they are also critically restorative."

– Colleen Yeakle, Indiana Coalition Against Domestic Violence[112]

2. **Strong social networks and trust** include trusting relationships among community members built upon a shared history, mutual obligations, and opportunities to exchange information that foster the formation of new, and strengthen existing, connections.[113] In the context of DV, social networks and trust are referred to in the literature as ***social cohesion***. Social cohesion is defined as mutual trust and solidarity in a community or a neighborhood. Strong social cohesion is associated with reduced risk for DV.[114 115 116] People who live in neighborhoods with high levels of social cohesion are more likely to be connected to a positive social network and less likely to experience social isolation,[117 118] a risk factor for DV.[119] Instead they are more likely to experience ***social inclusion,*** the process of supporting individuals and groups to take part in society. Social inclusion is named as a structural determinant of health for CDC's DELTA Focus project[120] and is a dimension of social cohesion, as inclusion is a necessary condition for mutual trust and solidarity in a community or neighborhood.[121] Additional related concepts in the research literature include neighborhood cohesion[122] and community cohesiveness.[123] It is important to note that some cohesive communities with strong social networks are tolerant of DV and may in fact increase the risk for DV. For example, one study found that adolescent and young adult males in dense, mostly male peer networks that are tolerant of DV have higher rates of DV perpetration.[124]

3. **Strong participation and willingness to act for the common good,** is characterized within the THRIVE framework as the individual capacity, desire and ability to participate, communicate and work to improve the community; meaningful participation by local /indigenous leadership; and involvement in the community such as through local community and social organizations and participation in the political process.[125] Such community mobilization is referred to in the literature in several different ways, including ***collective efficacy*** and ***strong community sanctions against DV***. Collective efficacy, a group or community's shared belief in the ability of the group to act effectively together toward a common goal, and strong community sanctions, legal prohibitions as well as moral and social pressure from the broader community against DV, are both protective against DV.[126 127 128 129] Evidence suggests that strong community sanctions against DV reflect community willingness to act to address DV as a community issue, which deters perpetration of DV while fostering support for survivors.[130]

Place Cluster

4. **What's sold and how it's promoted, i.e., healthy media and ways of promoting products** is the availability and promotion of safe, healthy, affordable, culturally appropriate products and services in a community.[131] In the context of safe relationships, this plays out in several important ways:

   a. ***Media and marketing practices that support healthy and equitable relationships*** portray healthy and equitable relationships and limit negative norm-enforcing media and advertising. Because of the power of media consumption and marketing in shaping behavior, it is likely that such media and marketing practices would be supportive of safe relationships.

   b. ***Low alcohol outlet density and availability*** is associated with lower rates of DV-related police calls and DV-related crime reports.[132] Thus the reduction of alcohol outlet density and availability is likely to contribute to greater safety and less violence in relationships.[133]

5. **Safe, stable and affordable housing** entails the existence of high-quality, safe housing that is accessible for residents with mixed income levels, and is associated with a number of positive health and safety outcomes.[134] Housing security can contribute to family stability and well-being, and the ability of families and the community as a whole to dedicate resources toward strengthening social cohesion. Specific housing design elements may also strengthen safety and cohesion within a community, by promoting social interactions and access to open space, which is associated with lower rates of violence. Efforts to reduce the density of public housing, beautify the surroundings, and integrate public housing into healthy communities rather than creating areas of highly concentrated poverty holds promise for increasing social cohesion and reducing community violence.[135] Proximity to nature and green spaces may reduce violence: trees, shrubs, grass and vegetation have been shown to improve mental health, reduce violence and aggressive behavior, and make residents feel safer.[136 137] Housing is also closely linked to poverty and is often considered a proxy indicator for socio-economic status. Ensuring safe stable housing for populations disproportionately impacted by DV could lead to reduced unemployment and

improved socio-economic status. Violence and fear of violence alters people's use of public spaces, and community design can improve perceptions and reduce crime and violence. Violence is less likely when city environments are designed to be safe for public use and promote a sense of security rather than fear.[138] Much of the research on the connections between housing security, housing design, and related factors focuses on community violence prevention, as well as links to improved neighborhood collective efficacy.[139] [140] Further study on the role of safe, stable and affordable housing and DV prevention is needed.

*Equitable Opportunity Cluster**

6. **Access to living wages and local wealth** consists of local ownership of assets; accessible local employment that pays living wages and salaries; and access to investment opportunities.[141] Access to these resources plays out within communities and families as ***family and community economic security.*** In addition to the availability of living wages and existence of local wealth, family and community economic security is more largely characterized by the economic ability of a community to securely meet basic needs. Family and community economic security contribute to family stability and well-being, and the ability of a community to dedicate resources toward social capital building activities, which all support safe relationships.[142]

Overarching Community Factors: Community Safety and Community Healing

Community safety and community healing is more likely with structural empowerment/enfranchisement and equitable distribution of power and resources. Improved community safety and community healing can address the psychological, physical and spiritual injuries that decades of inequity and violence have caused. Healing practices are often rooted in cultural knowledge and practices that allow community members to reconnect to one another, their environment and their past.[143] Community healing strategies vary depending on the histories and traditions of each community but can include healing circles, trauma informed community building, restorative justice programs, workforce development and more.[144] Both community healing and

* *According to the CDC, low academic achievement has been established as a risk factor for DV victimization and perpetration at the individual level and thus educational opportunity may impact the likelihood of violence in a community. However, research findings on the influence of education on DV prevalence at the community or neighborhood level have been mixed. While education is clearly linked to poverty and economic insecurity, which is associated with DV, according to Beyer, Wallis, and Hamberger's systematic review of research in U.S. settings (2015), the relationship between educational attainment and DV prevalence may not be significant at the community-level when economic factors are controlled for. Therefore, education is not included as a community determinant in this paper.*

community safety are made possible by the presence of community determinants that foster safe relationships and create the community conditions that allow those determinants to become engrained within a community, reinforcing cycles of safety and healing among families and the larger community for multiple forms of violence. Due to this reciprocal relationship, Prevention Institute has identified community safety and community healing as overarching community factors that can foster safe relationships and reduce DV. Improving community safety and community healing would result in potential outcomes such as: increase in trust between community and government including law enforcement; increase in perceptions of fairness; and an increase in measures such as social cohesion, social networks and trust, community efficacy, and multi-generational connectedness.

Survivor Measures of Success Align with Changing Community Conditions for Prevention

The Full Frame Initiative (FFI) is a national non-profit with an approach to DV prevention that is focused on survivor-centered, community-based solutions. In their report, *How do Survivors Define Success,* FFI explored how survivors of domestic violence in California define their success.[145] The report found that survivors primarily identified non-service related indicators as measures of their success. The four most common archetypes of success identified by survivors were: *social connectedness; belonging to something bigger than me; having and creating value;* and, *opportunity*. These measures go beyond individual services and situate individual experiences in the broader community context and conditions of those experiences.

Improving community context and community conditions can support the success of survivors and also help to prevent DV. For example, survivors' measures of "belonging to something bigger than me," might relate to social networks and trust. Strong social networks and trust are needed to both support survivors and promote safe relationships, both of which ultimately support a reduction in DV.

Diagram 4 shows the environment associated with safe relationships and reduced DV, including structural drivers, community determinants, and overarching factors.

The Trajectory of Safe Relationships and Reduced DV

Counter to the Trajectory of DV and DV Inequities, the Trajectory of Safe Relationships (Diagram 5) illustrates how improving the structural drivers and community determinants that increase the risk of DV can help foster safe relationships and decrease the incidence of DV. The diminishing size of the circles from left to right indicates the importance that structural drivers and community conditions have on fostering safe relationships. The community environment in this trajectory is compromised of the three interrelated community environments: people, place, and equitable opportunity.

Diagram 4: The Environment Associated with Safe Relationships and Reduced DV

Diagram 5: The Trajectory of Safe Relationships and Reduced DV

The trajectory illustrates visually how the continuous and reciprocal interplay of factors within the environment (structural drivers, the community environment, community determinants, and overarching community factors) can fundamentally shape exposures and behaviors, and thereby contributes to safe relationships and reduced DV. The trajectory demonstrates that structural drivers and the community environment, including community determinants, can have significant impact on shaping exposures and behaviors, and thereby support safe relationships and reduced DV. The trajectory is not a linear model and is not predictive, nor does it suggest causality. Rather, it depicts the complexity of interrelated factors that can support safe relationships and reduced DV.

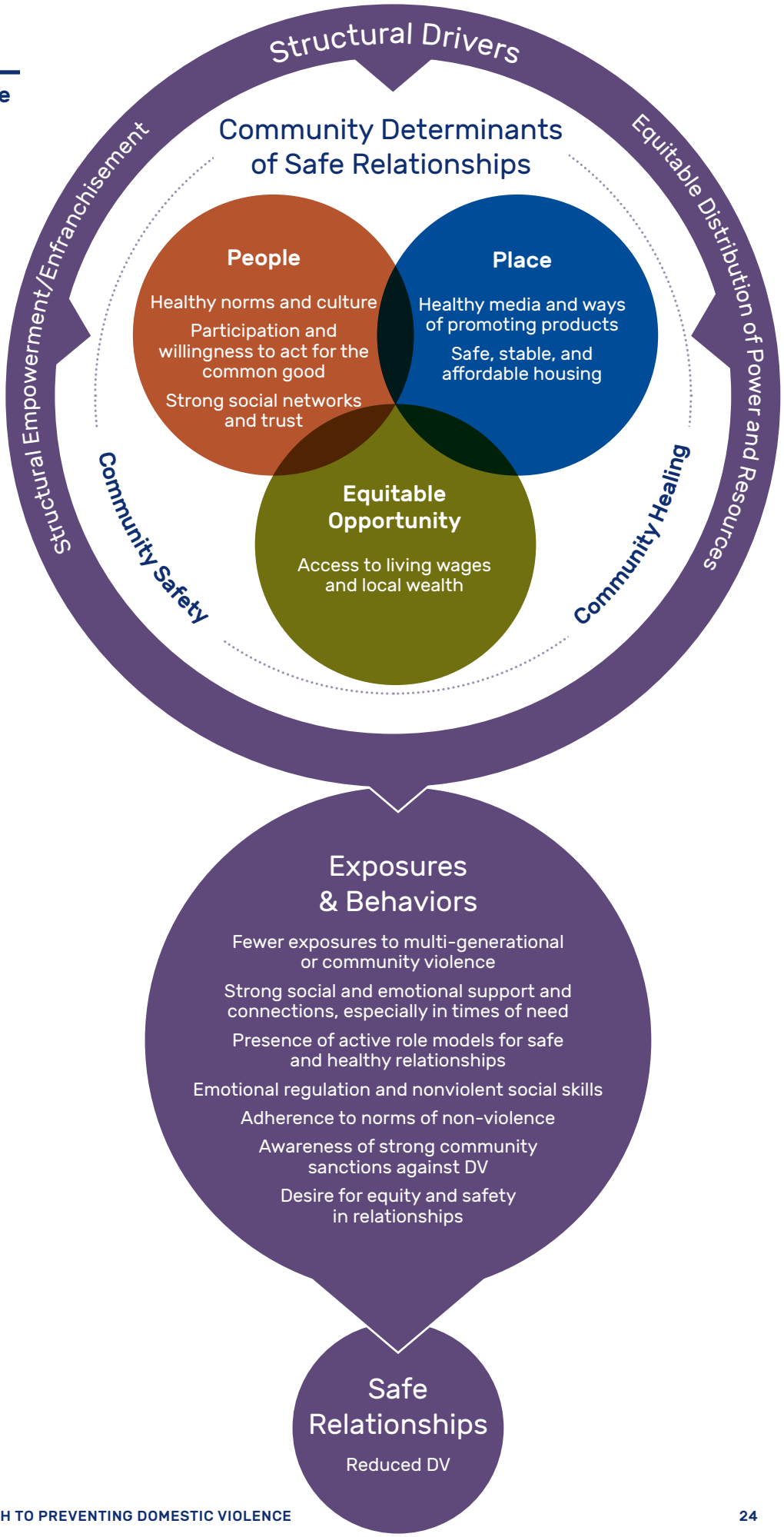


Table A: Community Determinants (THRIVE Factors) Associated with DV and Safe Relationships

This table summarizes how six of the THRIVE factors and two overarching community factors apply to DV and to safe relationships.

THRIVE Factor	THRIVE Factor Definition	THRIVE Sub-Factors for DV and Safe Relationships
Socio-cultural Environment (People Cluster)		
Norms & Culture	Broadly accepted behaviors to which people generally conform that promote health, wellness and safety among all community residents; discourage behaviors that inflict emotional or physical distress on others; and reward behaviors that positively affect others.	Harmful norms such as **norms that support gender inequities in relationships, norms supportive of violence** and **norms of non-intervention in family matters** reinforce power disparities within relationships, condone the use of violence to solve problems, and discourage community intervention. Conversely, healthy norms and culture such as **norms that support healthy and equitable relationships, norms supportive of non-violence, and norms that support engagement in family matters** can support safe relationships.
Social Networks & Trust	Trusting relationships among community members built upon a shared history, mutual obligations, and opportunities to exchange information and that foster new connections.	Weak social networks result in **distrust** and increased **social isolation** within communities, a known risk factor for DV whereas **social cohesion and inclusion** improves trust and solidarity between community members and fosters healthy community relations.
Participation & Willingness to Act for the Common Good	The capacity, desire and ability to participate, communicate and work to improve the community; meaningful participation by local/indigenous leadership; and involvement in the community through community and social organizations and participation in the political process.	**Weak community sanctions**, i.e., the lack of legal sanctions and moral or social pressure from the broader community to intervene to address and prevent DV, reflect low community capacity to address and prevent DV as a community issue. This low participation and willingness to act enables perpetrators to use violence with relatively little fear of repercussions while discouraging survivors to seek support. **Strong community sanctions against DV** reflect community participation and willingness to act to address DV as a community issue, which deters perpetration of DV while also fostering support for survivors.

THRIVE Factor	THRIVE Factor Definition	THRIVE Sub-Factors for DV and Safe Relationships
Physical/Built Environment (Place Cluster)		
What's Sold & How it's Promoted	The availability and promotion of safe, healthy, affordable and culturally appropriate products and services.	**High alcohol outlet density and availability** is correlated with higher rates of DV, while **low alcohol outlet density** is associated with reduced rates. **Media and marketing practices that reinforce harmful norms and culture** are associated with increased sexual aggression and inequitable gender norms in intimate relationships. Conversely, **media and marketing practices that support healthy norms and culture** promote and reinforce safe behaviors in relationships.
Housing	High quality, safe and affordable housing that is accessible for residents with mixed income levels.	**Housing insecurity**, including difficulty paying rent or bills, frequent moves, and overcrowded living conditions, is closely linked to increased risk of DV. Access to **safe, stable and affordable housing** with supportive design increases family stability and health, and improves social networks and trust, thus reducing the risk for DV.
Economic/Educational Environment (Equitable Opportunity Cluster)		
Living Wages & Local Wealth	The local ownership of assets; accessible local employment that pays living wages and salaries; and access to investment opportunities.	**Family and community economic insecurity** often plagues entire communities with instability and concentrated disadvantage making it difficult for many to provide necessary resources to their families. Conversely, **family and community economic security** increases the ability to securely meet basic needs.
Overarching Community Factors		
Community Violence	Intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim, characterized by its shared widespread impact and cyclical nature within the community.	Exposure to **community violence** is associated with an increased risk for DV. High rates of community violence negatively impact social networks, economic and housing security, and other determinants that increase risk of further DV. Conversely, **community safety** is protective and supportive of resilience factors such as strong social networks, economic security, stable housing, etc.
Community Trauma	Community trauma is the cumulative and synergistic impact of interpersonal violence, historical and intergenerational violence, and exposure to the impact of structural drivers of inequity.	**Community trauma** negatively alters community environments and reinforces systems and cycles of disenfranchisement, inequity, and multiple forms of violence**. Community healing** can reduce the risk for multiple forms of violence and strengthen multiple factors that support safe relationships.

Coming Together

A Multisector Approach to Fostering Community Environments that Support Safe Relationships

Community Settings And Sectors — Collaboration Multiplier Analysis, Part I

The actions of multiple sectors shape the community determinants of DV and DV inequities and the community determinants of safe relationships. A multisector approach that focuses on the roles of multiple sectors offers an actionable way to address these interrelated community determinants. A multisector approach also addresses the ways that structural drivers of inequity shape the community environment and offers concrete ways that action at the community level can push back on the structural drivers of inequity. DV can be prevented and inequities in DV can be reduced by addressing how structural drivers play out in the community environment and by fostering community environments that support safe relationships.

A multisector approach to DV prevention recognizes the importance of engaging community residents and organizations in understanding and addressing DV.

Community engagement is essential for ensuring that community culture is addressed in a positive manner, and that solutions build, rather than diminish the ability of the community to determine its priorities and take action on its own behalf.

Analysis of the literature and interviews confirmed that the following 11 sectors have significant influence in shaping the community determinants of DV and of safe relationships:*

* *While the education sector is an important sector in the prevention of adolescent dating abuse, given this paper's focus on prevention of adult DV, it was not included as a sector in the analysis.*

"It's important to look at the factors in communities that contribute to DV holistically. Different organizations can prioritize what makes sense to focus on, and collectively, coalitions can have a broad, coordinated impact."

– Jacquie Marroquin, California Partnership to End Domestic Violence[146]

1. The public **housing sector** provides stable affordable housing and creates opportunities for residents to become self-sufficient and contribute to their communities. It addresses the housing needs of homeless, people with low average incomes, older adults, and veterans, and ensures the availability of adequate affordable housing to meet future workforce needs based on growth projections.
2. The **community development** sector supports community infrastructure and economic development projects, including installation of public facilities, community centers, housing rehabilitation, and public services, and participates in code enforcement, homeowner assistance, and addressing many other community-identified needs.
3. The **planning sector** manages and maintains land for the maximum benefit of the public, including reviewing and approving land development and use.
4. The **zoning sector** designs the physical environment of communities and its structures so that all spaces are used as intended and for the maximum benefit of the public. Planning and zoning fundamentally shapes the layout and look of a community by making decisions that affect alcohol density, housing density, and the mix of business and residential uses. Sound planning and good design promote safety and quality of life for all residents.
5. The **business sector** provides goods and services typically in exchange for money with the ultimate goal of generating a profit and conducting business in ways that advance the interests of shareholders and/or the business owner within the boundaries of laws and ethics. The sector is a large employer of community members. In this paper, we discuss this sector with respect to its role as a workplace.
6. The **workforce development sector** assists people who are looking for work by providing job services and training, such as mock interviews, job leads, resume advice and professional certifications. It identifies promising candidates and helps employers fill openings and retain a full complement of employees. This sector also anticipates future labor market trends to help job-seekers develop skills that are or will be sought after.
7. The **sports sector** includes local professional leagues as well as non-professional leagues, clubs and sports programs offered through schools, parks and recreation departments, and community-based and civic organizations.

8. The **entertainment sector**, for the purposes of this paper, refers to the specific segment of the private business sector that provides entertainment media, usually for profit.

9. The **faith sector** is composed of organized religious institutions and faith leaders that provide spiritual guidance and counsel and a sense of belonging. The primary mandate varies by faith and can be broad in nature. At its core, however, each faith community provides a connection to religious and spiritual teachings, and engages members in its practices and belief systems.

10. The **healthcare sector** provides quality, culturally competent care that includes primary and preventative care, emergency services, and long term care. Increasingly the healthcare sector is working to reduce healthcare costs and improve population health while providing high-value, effective care through education, engagement, and linkages to community services.[147] Further, some healthcare providers are playing an active role in addressing the community determinants of health and safety, through for example, implementing Prevention Institute's Community Centered Health Homes (CCHH) model (see page 44).

11. The **social services sector** aids and protects vulnerable populations through a wide range of services designed to improve well-being and foster self-sufficiency. This sector serves many people and their families, including children and youth, those with disabilities and other special needs, elderly individuals, veterans, immigrants, and refugees.

These 11 sectors were prioritized primarily based on an analysis of the degree to which they can influence multiple community determinants. Consideration was also given to the degree to which there may be sustained opportunity to engage these sectors in taking action to prevent DV and DV inequities, and the degree to which sectors were already engaged in DV prevention, and aligned with other statewide prevention assets and strategic directions in California.

Together, the housing, community development, planning, and zoning sectors can be thought of as the sectors that shape *where we live.* Similarly, the business and workforce development sectors can be thought of as the sectors that shape *where we work*. The sports, entertainment, and faith sectors shape *where we connect and play.* The healthcare and social services sectors represent the sectors *where we receive care*.

In addition, DV service providers can be thought of as its own sector; that is, the sector *where communities find support and leadership on DV*. The **DV services sector** is a diverse group of service agencies and other types of organizations that provide a variety of comprehensive supports to survivors of DV and their families, advocate for policy changes, and build reciprocal expertise to strengthen DV intervention and prevention. DV services can include housing assistance and shelters, emergency planning, employment assistance, public benefit assistance, prevention programs, and more.

And finally, the **public health sector** is another critical sector, as it is *where communities find leadership on a prevention approach to health and safety*. Public health promotes and protects the health of people and the communities where they live, learn, work, and play.[148] The public health sector can make several unique contributions to DV prevention, including leadership, the ability to convene multiple sectors, resources, data, and expertise in population health promotion, research, planning, and evaluation.

Each of these 13 sectors (the 11 sectors that have *significant* influence in shaping multiple community determinants, plus the DV services sector and the public health sector) influence community determinants of DV. All settings and sectors influence the sociocultural environment, and can, for example, work to support stronger social networks and trust and community sanctions against DV. Changing harmful norms and culture has long been understood as an important DV prevention strategy. Numerous campaigns and initiatives have challenged the notion that DV is a private family matter and worked to interrupt harmful norms, such as norms that support gender inequities in relationships, and norms of non-intervention in family matters. A multisector approach supports norms change through direct efforts, as well as through actions to change other factors in the community environment such as harmful media and marketing practices, that also have an impact on norms. Since the community determinants of DV are interrelated, actions to promote one factor can impact other factors. For example strengthening family and community economic security and reducing community violence can in turn strengthen social networks and trust.

With respect to norms and culture, different settings and sectors may present unique opportunities for norms change. For example, in the business and workforce development sectors, norms of non-intervention in family matters can be challenged, and norms supportive of engagement in family matters can be promoted. In the healthcare and social services sectors, norms that support gender inequities in relationships can be challenged and norms that support healthy and equitable relationships can be promoted.

To assess the opportunities to improve community determinants within each of these sectors, Prevention Institute applied its Collaboration Multiplier tool methodology. Phase I of the methodology focuses on collecting information on key sectors to build an understanding of their perspectives, mandates, and potential contributions to preventing DV. Tables B, C, D, E, and F provide a snapshot summary of the mandate, main activities, and sample data collected for each sector and a list of the community determinants that these sectors influence.

Understanding the mandate of each sector can help to shed light on why a sector might have an interest in contributing to the prevention of DV. For example, when a school understands that students have difficulty focusing and learning when they feel unsafe due to adolescent dating abuse, they are more likely to integrate efforts to promote safe adolescent relationships into their school climate improvement efforts, as well as curricular and extra-curricular programming. Without this understanding, efforts to promote safe relationships may be seen as unnecessary or even taking away from the pursuit of other educational outcomes. Thus, the information gathered during Phase I of the Collaboration Multiplier analysis helps to illuminate potential strategies to reduce rates of DV that can be supportive of a sector achieving its mandate and desired outcomes.

In assessing the potential roles that sectors can play in promoting safe relationships, Prevention Institute considered a set of health equity principles, which are outlined in Appendix B. These principles provided guidance on how potential efforts can address the ways that structural drivers shape community determinants.

Where We Live – Housing/Community Development and Planning/Zoning Sectors

We conduct our private intimate relationships *where we live.* Though we may think of the walls of our homes as the contained boundaries of where we live, in fact, where we live extends into the shared spaces that

Table B: Collaboration Multiplier Phase I: Information Gathering Grid
Where We Live – The Housing/Community Development and Planning/Zoning Sectors

	WHERE WE LIVE **Housing and Community Development**	**Planning and Zoning**
Mandates	Preserve and expand safe and affordable housing opportunities; ensure there is adequate affordable housing to meet future workforce needs; promote strong communities	Manage and maintain land for the maximum benefit of the public
Main Activities	**Housing:** Preserve aging housing stock, develop and maintain public housing properties, and provide federally-subsidized rental vouchers for households with low average incomes **Community Development:** supports infrastructure and economic development, including installation of public facilities, community centers, housing rehabilitation, and public services, and participates in code enforcement, homeowner assistance, and addressing other community-identified needs	Review and approve land development and use, issue building permits, manage transportation planning, assess proposals for public/private development, create and amend municipal and zoning codes, and write comprehensive and neighborhood plans for cities and municipalities
Sample Data Collected	• Housing costs • Number of vacant housing units • Number of foreclosures • Requests for services and participation in programs within housing developments	• Permitted uses of land • Current and future land uses • Quality-of-life indicators • The effects of historic and current land use
Community Determinants Influenced	> Norms that support healthy and equitable relationships > Norms supportive of non-violence > Norms that support engagement in family matters > Social cohesion and inclusion > Strong community sanctions against DV > Low alcohol outlet density > Media and marketing practices that support healthy norms and culture > Safe, stable, and affordable housing with supportive design > Family and community economic security	

"Affordable housing is critical for promoting stability in people's lives and minimizing disruption and disconnection. This is needed for victims of domestic violence and is also necessary for supporting safe and stable families."

– Shamus Roller, Housing California[149]

connect homes to other elements of our neighborhoods. The housing and community development sectors (combined here as housing/community development) and the planning and zoning sectors (combined here as planning/zoning) significantly shape where we live.

California Context

Housing affordability and prevention of homelessness are major issues of concern in California. DV advocates at the state and local levels are working to promote policies and practices that strengthen housing stability for DV victims.[150] For example, the California Partnership to End Domestic Violence (the Partnership) sponsored AB418, which recently went into effect in California, protecting and strengthening safety options for survivors who terminate their leases in dangerous situations.[151] This bill and similar efforts promote housing and economic stability for survivors of DV, and protect against future violence. The Partnership and member organizations have also been vocal in supporting broader efforts to prevent homelessness.

Increasing numbers of communities across California and the country are partnering with the housing/community development sectors to address a number of health, safety, and health equity issues. This trend can be seen through a number of place-based comprehensive community change initiatives, and an effort by organizations like the California Planning Roundtable to understand and address the social determinants of health.[152] At a broader level in California, the Governor's Office of Planning and Research in its 2015 update of California's General Plan Guidelines (that address the design of public spaces, transportation, land use, environmental resource management, and housing development), incorporated guidelines for the first time to address issues related to public health and health equity, though the guidelines do not explicitly address DV as a health equity issue.

Opportunities to Improve Community Determinants

Increasing access to safe, stable, and affordable housing and improving protections against displacement and other sources of instability for California's families can in and of themselves lower risk for DV. Reducing alcohol outlet density and reducing media and marketing practices that reinforce harmful norms and culture

"It is unheard of or rare for planners to talk about DV but they do talk about social cohesion, community participation, and creating spaces for neighbor interaction. There is great opportunity to expand the conversation so planners consider how land use and housing policies, design, and programs can encourage or prevent violence, both within the home and in the streets."

– Beth Altshuler, Raimi and Associates[153]

in the places that surround housing can also lower the risk for DV. Improvements in these determinants can influence and improve other determinants. For example, the design of the spaces where families live shapes social dynamics, norms, and patterns of engagement and/or isolation. Mapping and altering the physical space in schools and how people interact in the school physical space is a demonstrated successful strategy for reducing adolescent dating abuse and sexual violence.[154] Similar strategies can be applied to the prevention of adult DV. Improving the design of environments where people live, such as increasing open space, green space, and places to connect socially within and surrounding housing environments can strengthen social networks and trust, improve perceptions of safety, and reinforce healthy norms and culture.[155] With intentionality to specifically address the norms associated with DV, all of this can contribute toward stronger community sanctions against DV and greater supportive engagement in family matters.[156] More broadly, these sectors can partner with other sectors such as business and workforce development, as well as healthcare and social services, to support families in being able to access economic resources and other resources and supports. With any efforts intended to improve the physical environment and make communities safer it is important to keep in mind the unintended consequences that often occur with physical and economic investments. Along with partners, the housing/community development and planning/zoning sectors can actively build anti-displacement and anti-gentrification strategies into all new policies and developments in order to avoid disrupting the existing social and cultural connections that exist within many communities.

Example of Housing/Community Development Sectors in Action:

- BRIDGE Housing Corporation, a leading nonprofit developer in California, has partnered with HOPE SF, a public housing revitalization initiative, and residents of Potrero Terrace and Annex, to rebuild two large distressed public housing sites located in the Potrero neighborhood of San Francisco, California using trauma-informed community building (TICB). The groups are working together to improve the community environment and promote community healing and resilience through the creation of a high-quality, mixed-income housing development. Efforts include promoting community safety through design (e.g., through street-facing buildings), offering community spaces,

"Workers who are not safe at home and in their relationships are less able to focus and be productive at work. So let's pierce the privacy norm between work and home life. And let's realize that workers are community members. That means when we shift workplace norms about work and family life, and shift norms about acknowledging and addressing trauma, it can extend out to shift community norms.

– Devorah Levine, Contra Costa County Alliance to End Abuse[157]

economically integrating the community, and encouraging social connectedness. Taking a trauma-informed approach to community building includes listening to community voices to address needs and create a shared vision throughout all phases of planning. "Community-builders" are on-site interacting with residents, offering leadership development opportunities, and supporting community projects.[158] This example of trauma-informed community building is already working to strengthen several community determinants that support safe relationships, such as safe, stable, and affordable housing, and strong social networks. These efforts could be expanded to explicitly address DV.

- The PASS (Promoting Adolescent Sexual Health and Safety) program, located in the historically underserved neighborhood of Benning Terrace in Washington D.C., involves partnerships with residents, the D.C. housing authority, and local community-based organizations to improve health and social outcomes for girls at risk of intimate partner and sexual violence. The community-based program involves training for youth and adults in sexual safety and health to challenge unhealthy norms, focusing on gender dynamics, communication skills, peer leadership, and sexual health education.[159] Social, cultural, and lived experiences are integrated into the curricula to address the needs of the community and to gain community trust.[160]

Example of Planning/Zoning Sectors in Action:

- The City of Baltimore is working to reduce multiple forms of violence through a zoning code, which limits the number and density of alcohol outlets in high-poverty neighborhoods. The goal of the zoning code is to reduce the number of alcohol outlets in Baltimore to comply with the CDC recommendation of one alcohol outlet per 1,000 residents. This would mean a reduction of around 700 outlets throughout the city. The City of Baltimore views the reduction of alcohol outlets as a key step toward reducing violence and creating a healthy and safe city for all residents.[161]

Table C: Collaboration Multiplier Phase I: Information Gathering Grid
Where We Work – The Business and Workforce Development Sectors

	WHERE WE WORK Business	Workforce Development
Mandates	Generate profit; provide goods and services; create demand and meet supply needs	Prepare workers to be ready for and successful in employment
Main Activities	Produce, market, distribute and/or sell goods and services; develop and employ a workforce; research and develop new products and technologies.	Providing job training and services to enhance skills and readiness for work, matched to available employment; address barriers to employment, e.g. transportation
Sample Data Collected	• Employee hours and earnings • Illness and injury on and off the job • Lost productivity due to absences • Labor costs, including healthcare costs	• Workforce conditions and trends • Employment barriers • Unemployment rate • Average wages
Community Determinants Influenced	> Norms that support healthy and equitable relationships > Norms supportive of non-violence > Norms that support engagement in family matters > Social cohesion and inclusion > Strong community sanctions against DV > Safe, stable, and affordable housing with supportive design > Family and community economic security	

Where We Work – Business and Workforce Development Sectors

Norms of privacy and non-intervention in family matters promote the perception that our intimate relationships and our work lives are conducted in separate, unrelated spheres. But *where we work* influences numerous factors that shape our personal relationships and family lives. The business and workforce development sectors significantly shape where we work.

California Context

Addressing trauma and violence as a barrier to employment and promoting workplace safety are major concerns in California. The CalWORKs' online appraisal tool now includes screening for DV, as part of a state mandate. As a result, local social service departments are

"We are having more success in passing supportive workplace policies, like family leave and paid sick days. But implementation requires a cultural shift so that family needs are not considered a personal problem, but something that workplaces support. This is needed so that workers are comfortable using the rights they have."

– Jenya Cassidy, California Work and Family Coalition[162]

training their staff on how to conduct the DV screening, and how to do so in a trauma-informed manner. Initial efforts show the limitations of implementing the mandate with staff training alone, and therefore, there is a move to acknowledge and address trauma as a broader issue and to implement organization-wide practices to make the entire agency trauma-informed.[163] Moving beyond trauma response, Futures Without Violence is implementing the Low Wage, High Risk Pilot project through its Workplaces Respond to Domestic and Sexual Violence initiative, and working with employers to implement comprehensive workplace violence prevention policies. While the pilot project does not currently have a California site, Futures is actively conducting outreach in California.[164] Additional relevant efforts include the California SafeCare Standard, a campaign against workplace violence in the healthcare industry.[165] This standard against workplace violence is being considered by CalOSHA. One of the original intents and some of the underlying themes stressed by the campaign is the fact that workplace violence is closely related to partner violence. Further, as a result of advocacy efforts, state mandates, and emerging approaches to management, segments of the business and workforce development sectors in California are increasingly addressing and improving family support policies and issues related to violence and trauma.[166]

Opportunities to Improve Community Determinants

Improving family and community economic security through living wages, secure employment, and better working conditions can decrease levels of family and community stress, conflict, and instability, while increasing the number of families that can afford the cost of housing. This is particularly true among businesses that presently pay women of color and immigrant women low wages with poor working conditions, such as for domestic work, and in tipped-wage service industries. Businesses can implement internal policies and practices to influence norms and create working conditions that support safe relationships. For example, businesses can foster organizational culture that supports utilization of family leave policies and related policies and practices to support the ability of both women and men to care for family members. Research suggests that access to paid maternity leave may help protect against intimate partner violence.[167] Employers can also proactively help their employees understand the connection between relationship health and physical health, and promote healthy norms and culture, including norms that support healthy and

"Transforming the work place to prevent and address domestic and sexual violence is more than passing a policy. It's not a campaign. It's deep, committed, relational, long-term work to build capacity and to address power and safety and shift the culture of violence."

– Ana Polanco, Futures Without Violence[168]

equitable relationships, norms that support non-violence and norms that support engagement in family matters. This would extend beyond individual employee education and include integration of efforts into employee wellness and other organizational policies, practices and programs. Businesses can also promote strong community sanctions against DV. On the workforce development side, efforts focused on job skills and readiness could also infuse existing training with content related to social-emotional skills, promotion of healthy norms and culture, workplace safety, and employee rights and responsibilities related to harassment and violence.

Examples of Business and Workforce Development Sectors in Action

- Workplaces Respond to Sexual and Domestic Violence Initiative, a project of Futures Without Violence, has introduced a Low Wage, High Risk pilot site program to address the needs of low-wage workers in the face of gender-based violence and exploitation in the workplace. The project focuses on retail, food service, hotel, homecare, and agricultural industries where workers face large risks. Working within the existing power structures of these industries, employers and supervisors are the first to receive training to create buy in at the top of the hierarchy and catalyze real organizational change for employees. Their three pilot sites, Immokalee, FL, Townsen, MD, and New York, NY are working with employers, community organizations, advocates against DV and employees to introduce policies and develop best practices that protect against gender-based violence in the workplace and ensure economic security.[169] [170]

- After the White House created its "It's On Us" campaign to fight sexual assault and domestic violence, Job Corps, a free federal education and job training program for young people, quickly embraced the mission to prevent DV or workplace sexual violence both internally and with their students. Job Corps has a tiered services system that involves yearly trainings for staff and requires a health and wellness curriculum for students that discusses sexual assault prevention.[171] As well, Job Corps offers social skills training to assist students in building healthy personal and business relationships.[172]

"We need to ask, where are the engagement points to reach community members, including decision-makers and leaders? It is critical that we engage community members, especially young adults, in prevention efforts that are focused on building healthy social norms that do not tolerate violence and abuse.

– Nancy Bagnato, California Department of Public Health[173]

Where We Connect and Play – Sports/Entertainment And Faith Sectors

The places *where we connect and play* are strong shapers of norms and culture, and social networks and trust, and can directly influence the degree of community sanctions against DV.

California Context

California has a rich history of engagement of the faith sector in DV prevention through investments by and partnerships between the California Department of Public Health and the Blue Shield of California Foundation. These efforts have resulted in leaders from diverse faith communities who have taken leadership on DV response with their institutions, and to some extent, have extended their work to include proactive prevention efforts. Mobilizing sectors where community members connect and play is consistent with a community mobilization strategy. Throughout California, rape prevention and education programs and DV prevention programs are assessing community engagement points and mobilizing where there is readiness, though this work largely centers on schools and promotion of safe relationships among youth.

Opportunities to Improve Community Determinants

The sports, entertainment, and faith sectors can influence community determinants such as norms and culture, social networks and trust, and community sanctions against DV. Sports teams, especially at the youth level, can influence norms and culture through culture building practices that include coaching, parent engagement, and player education. At a professional level, local sports teams and athletes can act as spokespeople for campaigns that promote healthy norms and culture and safe relationships. Sports teams can promote visibility among role models who challenge harmful norms.[174] Local entertainment businesses, such as local news outlets and movie theatres, can utilize media and marketing practices that support healthy norms and culture and reinforce safe behaviors in relationships. The faith sector can integrate themes of healthy norms and culture and safe relationships into religious and community services. The faith sector also plays a role in promoting family and community economic security and safe, stable, and affordable housing. All three of these sectors can adopt strategies described for the business sector, including promoting utilization of family leave policies by both women and men,

Table D: Collaboration Multiplier Phase I: Information Gathering Grid
Where We Connect and Play – The Sports, Entertainment, and Faith Sectors

	WHERE WE CONNECT AND PLAY Sports/Entertainment	Faith
Mandate	**Entertainment**: specific segment of the private business sector that provides entertainment media usually for profit **Sports**: includes both professional and non-professional leagues, clubs, and sports programs offered through schools, parks and recreation departments, and community-based organizations	Provide a connection to religious and spiritual teachings; engage members in practices and belief systems; provide charity and community support
Main Activities	Design, produce and market products and media messaging campaigns with the intention of making a profit, improving ratings, and developing a following of fans and consumers. Train for and perform competitive physical activities with the intent of entertaining or to earn income (professional) or to build social networks and gain physical and social skills (youth/non-professional)	Provide religious services and teaching; provide counsels to members; advocate for the community and its members; maintain a meeting place; provide charity
Sample Data Collected	• Number of DV instances among professional sports teams members • Money invested in DV prevention campaigns	• Number of funerals due to violence • Number of visits to hospitals and homes • Stories of loss and information on victims and survivors of violence
Community Determinants Influenced	> Norms that support healthy and equitable relationships > Norms supportive of non-violence > Norms that support engagement in family matters > Social cohesion and inclusion > Strong community sanctions against DV > Media and marketing practices that support healthy norms and culture	

promoting norms that support healthy and equitable relationships, norms that support non-violence, and norms that support engagement in family matters among employees through education and other practices, and through ensuring strong sanctions against DV.

Examples of the Sports and Entertainment Sectors in Action:

- Refuse To Abuse is a partnership between the Seattle Mariners and the Washington State Coalition Against Domestic Violence. The partnership brings in popular Mariners players and Managers who serve as spokespeople for the campaign, a local marketing company who helps creates the ads, and the media who have covered and promoted the ads. Refuse to Abuse helps raise the issue of DV prevention to a broad community audience.[175]
- A Call to Men is a domestic violence prevention organization that offers trainings and presentations to groups of men around the country. Recently, they have partnered with local advocates against DV to deliver trainings on domestic violence prevention and healthy gender norms to athletes who play on teams that are members of Major League Baseball, the National Football Association, the National Hockey Association, and the National Basketball Association.[176] [177]

Example of the Faith Sector Taking Action:

- The Marin Faith Communities Project launched a county-wide campaign during the Season of Nonviolence in order to raise DV awareness within their community. Through that campaign, they formed a collaborative partnership between Community Congregational Church of Tiburon, Marin Abused Women's Services, and the Marin Interfaith Council. That collaborative effort helped one of the participating churches to implement a Safe Church Policy that establishes a zero tolerance policy for DV and introduced specific protocols for DV response within the church.[178]

Where We Receive Care – Healthcare And Social Services Sectors

The care that we receive to support family and community health, stability, and wellness has a direct effect on our intimate relationships. The healthcare and social services sectors are the settings *where we receive care*.

Table E: Collaboration Multiplier Phase I: Information Gathering Grid
Where We Receive Care – The Healthcare and Social Services Sectors

	WHERE WE RECEIVE CARE **Healthcare**	**Social Services**
Mandate	Improve the health of patients	Promote the wellness and safety of vulnerable groups; connect individuals and families to resources for self-sufficiency
Main Activities	Deliver healthcare services, including preventive care, dental care, mental health services, screening and diagnosis, disease management and treatment, emergency services, and rehabilitation	Administer benefits, provide crisis services, including case management and emergency food, clothing, utilities, child care and safe shelter; and respond to abuse reports
Sample Data Collected	• Diagnosis and treatment (patient encounters) • Reasons for ER admissions • Quality of care • Patient satisfaction	• Reports of domestic violence • Reports of child and elder abuse • Requests for services • Participation in programs and events
Community Determinants Influenced	> Norms that support healthy and equitable relationships > Norms supportive of non-violence > Norms that support engagement in family matters > Social cohesion and inclusion > Strong community sanctions against DV > Family and community economic security	

"For a healthcare provider, a trauma-informed and client-centered approach to DV includes talking to everyone about it, not just taking a 'screen and treat' approach. It's about saying – we are here to address this as a community. We need to move into a new chapter and transform the role of the healthcare sector beyond case identification."

– Dr. Elizabeth Miller, Children's Hospital of Pittsburg[179]

California Context

According to the CDC, DV costs $4.1 billion dollars a year in direct medical and mental health expenditures each year.[180] In California and across the U.S., the healthcare system is being transformed from a system oriented toward treating sick individuals one person at a time, toward a system engaged in community prevention, in partnership with other sectors. The healthcare sector has been an important site of policy and practice development to strengthen responses to domestic violence (DV) within the clinic setting. Working in partnership with the DV services sector, and leading organizations such as Futures Without Violence, the Blue Shield of California Foundation has made valuable investments in integrating clinical healthcare and DV response systems throughout California. There is growing statewide momentum and local readiness to build on this important work to take action to prevent DV in the first place. Social services providers are also becoming more engaged in addressing DV, sometimes in partnership with healthcare providers.

Opportunities to Improve Community Determinants

The healthcare sector and social services sector have the potential to positively shape several community determinants of safe relationships. For example, these sectors can promote healthy norms and culture, including norms that support healthy and equitable relationships, norms of non-violence, and norms that support engagement in family matters. These sectors can also foster strong social networks and trust and community sanctions against DV. The healthcare sector in particular has the potential to make great contributions toward DV prevention because of its assets of credibility, knowledge of patient needs, vision, and experience in systems transformation.

Healthcare has played an active role in addressing community determinants to improve health conditions, like diabetes and asthma. For example, as a result of their heightened awareness of the role community determinants play in shaping health outcomes, clinics and healthcare groups have undertaken activities such as: fundraising to build a playground in a community with low average household incomes and high rates of chronic disease; working with legal aid groups to advocate for improved rental housing conditions; addressing environmental pollution and its contributing impact on health; and speaking up in favor of health promoting policies at city council meetings.[181]

"I would like to see health and public health included in any state or community wide violence prevention initiative. Health providers are trusted community messengers and have the potential to reach many people with messages of violence prevention."

– Lisa James, Futures without Violence[182]

By bridging prevention, population health, and healthcare, Prevention Institute's Community-Centered Health Homes (CCHH) model provides an emerging roadmap for healthcare engagement in DV prevention. Building upon the patient-centered medical home model, a CCHH not only provides high quality health services while acknowledging that factors outside the healthcare system affect patient health outcomes, but actively participates in improving those factors.

A CCHH works to address community determinants through, for example, gathering and analyzing data and using their standing in the community to advocate for change.[183]

A CCHH can also participate in multisector community coalitions that can include the housing/community development sectors, the business sector, and others, as well as social service providers. A CCHH can join existing multisector efforts and/or act in partnerships to co-create new efforts. Appendix C details examples of specific actions a CCHH can take through the elements of inquiry, analysis, and action to engage in community level prevention.

Examples of the Healthcare Sector in Action:

- Healthcare sector leaders can play important roles as spokesperson and policy advocate for prevention. For example, Dr. Liz Miller, Chief of the Division of Adolescent Medicine at Children's Hospital of Pittsburgh, provided expertise that helped to shape state adolescent dating abuse prevention legislation. As an individual citizen, she participated in legislative hearings to educate legislators on effective prevention. In addition, as a community leader, she helped to facilitate and support community-based prevention efforts, including at schools, after-school programs, and faith organizations.[184]
- Similarly, in response to a spike in murders and shootings across Chicago, Ann and Robert H. Lurie Children's Hospital of Chicago President and CEO Patrick Magoon submitted a letter to the editor to the Chicago Sun-Times advocating for multisector violence prevention strategies, including sustained investment in youth and communities. While this example is not specifically focused on addressing DV, it demonstrates how leaders of healthcare organizations can act as policy champions for multisector strategies to improve the community determinants of violence.[185]

- With support from Catholic Health Initiatives (CHI), Good Samaritan Behavioral Health partnered with the United Against Violence of Greater Dayton Coalition in Ohio to reduce violent crimes in four neighborhoods. With a strong focus on youth development activities, the partnership worked with schools, families, and local organizations to implement strategies to foster a neighborhood culture of nonviolence.[186] This partnership supported the implementation of Second Step, an evidence-based curriculum, in Dayton schools, active dialogue to promote positive youth-police relationships, and a widespread media campaign to "educate the greater community about multiple issues of violence and raise awareness around prevention."[187] As a result, there was a 21% reduction in violent crimes over three years in Harrison Township, a 9% reduction in Trotwood, a 33% reduction in North Riverdale and a 21% reduction in Westwood.[188] While this example is not specifically focused on addressing DV, it demonstrates how healthcare organizations can participate in community coalitions working to strengthen community determinants such as healthy norms and culture and strong social networks.
- Unemployment is a major driver of violence and poor health in New Orleans, Louisiana, particularly among African American men, who had an over 50% unemployment rate in 2015. Upon recognizing this, several healthcare providers decided to participate in the City's Economic Opportunity Strategy. Acting as an anchor institution, Ochsner Health System implemented a number of reforms to expand job opportunities, including establishing a Workforce Development Department, reviewing hiring practices for people with criminal records, increasing wages for more than 400 medical assistants, and delivering over 80 new hires and promotions for incumbent workers to career pathways in health care. LCMC Health hosted a match-making event between its procurement officers and local and minority-owned companies. Since the Economic Opportunity Strategy's launch in 2014, 1,000 disadvantaged job seekers have been connected to employment, the African American male under-employment rate has dropped from 52% to 44%, and the City's unemployment rate has dropped from 6.7% to 5.8%.[189] [190] [191] While this example is not focused on addressing DV, it demonstrates how healthcare organizations can participate in collaborative violence prevention strategies to improve economic opportunity for individuals at elevated risk for violence.

- Futures Without Violence and local DV organizations are building and strengthening partnerships with hospitals and clinics in communities across California to address DV, with generous support and partnership from the Blue Shield of California Foundation. Through the Domestic Violence and Health Care Partnerships (DVHCP) project, participating hospitals and clinics provide universal education to patients through cards with information on the characteristics of healthy and unhealthy relationships and how they both impact health. Patients are often provided with several cards and encouraged to share the information within their social networks.[192 193]
- The Baby Makes 3 program is a primary prevention partnership between Whitehorse Community Health Service and the City of Whitehorse Maternal Child Health Services in Victoria, Australia. With the goal of promoting equal and respectful relationships between expectant parents and preventing DV during the transition to parenthood, the program includes patient education and referrals to parent groups. Support groups and education programs on their own are insufficient for changing community determinants. That said, the program was successful in integrating prevention programming into the healthcare setting. Over 90% of participants shifted their views on gender norms and gender roles through their participation in the program.[194]

Example of the Social Services Sector Taking Action:

- The MEN (Making Employment Needs) Count Program was created to reduce the risk of HIV in vulnerable populations in Boston, Massachusetts. Due to the linkage between DV and risky sexual behavior, the program also looked at prevention of DV as an outcome. MEN Count integrated a gender equity curriculum into their peer counseling services and employment and housing case management services. The program was successful in changing attitudes about DV and gender norms.[195] Such efforts, when combined with multifaceted strategies such as policy and practice change, have the potential to create community wide change.

Where We Find Support and Leadership on DV – DV Services Sector

The DV services sector is where communities find support and leadership on DV. The DV services sector has decades of experience addressing DV at the local, state, and national levels and a vested interest in forming partnerships with different sectors to improve prevention of and response to DV.

California Context

Through a limited number of interviews, local and state leaders in California's DV services sector were asked to gauge the sector's investment and readiness to work across sectors to implement multisector prevention strategies. Several national leaders were also interviewed to understand wider trends and influences.

Table F: Collaboration Multiplier Phase I: Information Gathering Grid
Where Communities Find Support and Leadership on DV – the DV Services Sector

	WHERE COMMUNITIES FIND SUPPORT AND LEADERSHIP ON DV **DV Services**
Mandate	Meet the needs of DV survivors and their families. Provide the central voice and constituency for shaping and leading the future of DV prevention in California.
Main Activities	Connect survivors and their families to services such as housing assistance, emergency assistance, and other supportive services, provide prevention programming, and build coalitions.
Sample Data Collected	• Number of DV survivors, children, and other family members participating in services • Number and types of referrals to service providers • Number of community members participating in prevention education programs • Number and types of partnerships with sectors • Number and types of local and state policies implemented
Community Determinants Influenced	> Norms that support healthy and equitable relationships > Norms supportive of non-violence > Norms that support engagement in family matters > Strong community sanctions against DV > Family and community economic security

"Investing in prevention is a solution that will yield long-term benefits [...]. These strategies focus on building community and reducing isolation. Domestic violence organizations are making a difference. They're more than just crisis centers: they're hubs for building more peaceful communities."

– Jessica Merrill, California Partnership to End Domestic Violence[196]

Broadly speaking there is growing support and readiness for a focus on prevention of DV through a health equity and multi-sector approach.

The DV services sector has strong roots in grassroots, social justice organizing, and a deep commitment to addressing gender inequities as well as oppression based on race/ethnicity, socio-economic status, disability, sexual orientation, gender identity, and other factors. There is a growing conversation across the state, informed by reports such as *How do Survivors Define Success* and other long-standing efforts, to understand that a survivor-centered, social justice approach addresses the broader conditions that survivors seek for themselves, their families, and communities.[197] These conditions extend far beyond quality crisis services and assistance to collectively changing the factors that contribute to inequities and violence in the first place.

There is a strong history of multisector partnerships in California, and a growing readiness to expand those partnerships toward prevention efforts, especially in the healthcare sector and increasingly in the housing sector. For several years, the Blue Shield of California Foundation (BSCF) has made valuable investments in integrating healthcare and DV response systems throughout California. The DV and Health Care Partnerships (DVHCP) project is a strong example of multisector efforts that have seeded statewide momentum and readiness toward multisector prevention. There is also growing momentum and efforts in the DV services sector to organize around safe, stable, and affordable housing, especially for DV victims/survivors, and also, to promote DV prevention as an important element of the prevention of homelessness.

The DV services sector is rich with capacity and assets that can form the foundation for a growing health equity and multisector approach to DV prevention. These include experience and expertise in: forming and leading multisector partnerships; implementing systems changes; and, advocating for local and state policy change. The sector also has vitality with respect to regional and statewide leadership, learning networks, and communities of practice. With a long-term commitment to supporting survivors and investment in preventing future violence, the DV services sector provides the central voice and constituency for shaping and leading the future of DV prevention in California and acts as coalition builders across sectors and social movements.

While the sector shows readiness and interest in moving toward a health equity and multisector approach to prevention, there is very limited ongoing funding support for DV prevention efforts, and limited local and state infrastructure. Infrastructure refers to the relevant sectors and organizations at the local and state levels, how they are resourced and organized, how they function independently and collectively, and the interplay between the state and local levels. Through projects like the California DELTA project and the Domestic Violence Training and Education Program, the California Partnership to End Domestic Violence (the Partnership) and California Department of Public Health (CDPH) have been working to strengthen California's DV prevention infrastructure. They have made progress. At the same time, DV service providers and healthcare providers largely operate as or within safety net and service delivery systems to respond to DV, and are not organized, per se, for prevention. A health equity and multisector approach to preventing DV– especially in a state as large, diverse, and complex as California – requires facilitative local and state level infrastructure to support these efforts.

Valuable lessons have been learned about the critical elements of statewide infrastructure and the steps and processes for building these elements in fields addressing other health and safety issues. Similarly, important insights about state DV prevention infrastructure development have been gained through initiatives such as CDC's DELTA project and EMPOWER project and Robert Wood Johnson Foundation's DELTA PREP project. New models and theories for state infrastructure development are emerging to respond to economic and demographic trends and can be applied to ongoing efforts to strengthen California's DV prevention infrastructure.[198] [199]

Opportunities to Improve Community Determinants

The DV services sector plays an important bridge-building role in multisector efforts to improve community determinants, and plays a critical role in ensuring DV-specific issues are addressed and integrated into the actions of multiple sectors. In addition to playing important roles in creating safe environments for survivors, the DV services sector can advocate for local policy change for prevention. All of the multisector actions suggested in this paper will require DV expertise and leadership.

- **Example of the DV Services Sector in Action:** While focused on adolescent dating abuse, the DELTA FOCUS project, a state and local partnership between the California Partnership to End Domestic Violence and local coalitions lead by Peace Over Violence in Los Angeles, and the Alliance for Community Transformations in Mariposa County, is an example of the DV services sector playing a leadership role in bringing together multiple sectors (DV services, public health, education, and youth development) to address policies, practices, and norms to promote safe adolescent dating relationships.
- **Example of the DV Services Sector in Action:** See the Domestic Violence and Health Care Partnerships (DVHCP) project, page 46.
- **Example of the DV Services Sector in Action:** Through a public-private partnership, the California Department of Public Health, with the support of the Blue Shield of California Foundation, has focused prevention efforts on building the capacity of local domestic violence agencies to implement innovative community mobilization efforts in their communities, spearheaded by committed youth leaders who work with community members to identify strategies to promote healthy and safe relationships in their schools and the broader community. A long term goal of this effort is to increase the civic health of the community (e.g. safety, civic pride and involvement, social capital, community improvement projects).

Where We Find Leadership On Health and Safety – Public Health Sector

The public health sector is *where communities find leadership on a prevention approach to health and safety*. The public health sector has significant experience addressing DV as a public health issue at the local, state, and national levels, and a vested interest in forming partnerships with different sectors to promote safety and reduce violence.

Table G: Collaboration Multiplier Phase I: Information Gathering Grid
Where Communities Find Leadership on Health and Safety – Public Health Sector

	WHERE COMMUNITIES FIND LEADERSHIP ON HEALTH AND SAFETY **Public Health**
Mandate	Promote and protect the health of people and the communities where they live, learn, work, and play.
Main Activities	Conduct scientific research, educate about health, sets safety standards, track illness, injury, and death, advocate for improvements in other sectors.
Sample Data Collected	• Rates of DV by demographic factors • Number and types of DV prevention programs • Health impact of DV • DV prevention program evaluation • Number and types of local and state policies implemented
Community Determinants Influenced	> Norms that support healthy and equitable relationships > Norms supportive of non-violence > Norms that support engagement in family matters > Social cohesion and inclusion > Strong community sanctions against DV > Media and marketing practices that support healthy norms and culture

California Context

The California Department of Public Health (CDPH) has a longstanding history of leadership on DV prevention, including policy and program efforts that have engaged multiple sectors such as faith, healthcare, and DV services.[200] CDPH has played a strong partnership role in several DV prevention initiatives led by other entities, such as the California Partnership to End Domestic Violence's CDC funded DELTA and DELTA FOCUS projects. CDPH has also engaged other state agencies, such as the California Office of Emergency Services, and the California Department of Education. CDPH in fact is nationally recognized as a leader in violence and injury prevention and has played multiple roles in elevating DV as a public health, preventable issue. Further, CDPH is engaged in a process of internal alignment to develop a cohesive approach to preventing multiple forms of violence across divisions and branches within the department, including the Office of Health Equity.[201] At the local level, several Public Health Departments are engaged in addressing DV and are poised to engage more deeply in a health equity and multisector approach.

Opportunities to Improve Community Determinants

The public health sector is among the most important sectors in preventing DV, given its leadership and bridge-building role between sectors to improve the community determinants of a variety of health and safety issues.[202] In addition to these roles, at the state and local levels, the public health sector can collect, analyze and disseminate data and research, participate in coalitions, provide training and technical assistance, lead local and state prevention initiatives, and provide resources for others to lead local and state prevention initiatives.

- **Example of the Public Health Sector in Action:** The California Department of Public Health's EpiCenter, designed by the Safe and Active Communities Branch and constructed by the Information Technology Services Division, collects, analyzes, and disseminates data on intimate partner violence. The website includes a flexible custom table builder covering all injuries occurring in California to state residents where the outcome is death, hospitalization, or an emergency department visit.
- **Example of the Public Health Sector in Action:** Public health has played a role in bringing multiple sectors together to develop and evolve a statewide prevention agenda to address DV and other related forms of violence for over a decade. In 2006, the California Department of Health Services (CDHS) published the *California Statewide Policy Recommendations for the Prevention of Violence Against Women*. This document, developed in concert with state agencies, statewide coalitions, and service providers, summarized policy recommendations for the prevention of sexual assault, intimate partner violence, trafficking, and other forms of violence against women and girls. CDHS convened a multidisciplinary and multisector group of stakeholders, and collected, reviewed, and integrated ideas and policy issues from 22 relevant statewide and national planning and policy documents.[203]
- **Example of the Public Health Sector in Action:** The Santa Clara County Public Health Officer participated and played critical roles in the Santa Clara County Intimate Partner Violence Blue Ribbon Task Force (IPV Task Force). The IPV Task Force brought together the Santa Clara County IPV Community, nontraditional organizations, and individuals for an exploration and evaluation of the current service models and identification of additional research into best practices, treatment approaches, and integration of efforts to

prevent and address IPV. The goal of this project is to build an intentional, comprehensive focused prevention and intervention strategy dealing with IPV that involves diverse communities and multiple sectors.[204]

- **Example of the Public Health Sector in Action:** See the public-private partnership effort led by the California Department of Public Health with support from the Blue Shield of California Foundation described on page 50.

Addressing the Community Determinants of Multiple Forms of Violence

Multiple forms of violence such as DV, community violence, and child maltreatment are interconnected.[205 206] *Connecting the Dots,* a CDC and Prevention Institute report, details how community level factors such as harmful gender norms, high alcohol outlet density, and diminished economic opportunity are risk factors for multiple forms of violence.[207] Exposure to one form of violence significantly increases the risk of exposure to future violence and families often experience multiple forms of violence at the same time.[208] Research also shows that DV increases the risk for every type of violence,[209] which means addressing community determinants of DV can help prevent other forms concurrently. By recognizing the interrelatedness and co-occurrence of multiple forms of violence, the DV services sectors can partner with advocates and sectors working to prevent forms of violence, such as community violence and child maltreatment, to strengthen the shared community determinants that protect against these forms of violence.[210] Addressing multiple forms of violence also lends itself toward engagement with multiple social movements, including movements for racial and economic justice, as well as gender and reproductive justice, to center those who have been most marginalized at the core of the work.

Multisector Strategies For DV Prevention: Collaboration Multiplier Analysis, Part II

The identification of mandates, activities, and sample data, informs potential roles and sets the stage for the Collaboration Multiplier analysis, Part II, where joint assets/strengths, potential shared outcomes, and potential joint strategies among multiple sectors are explored. While the previous section addressed opportunities for specific sectors to address community determinants in a sole or leading role, research and practice has demonstrated that when multiple sectors work together they can achieve greater outcomes. When the focus is on the efforts of individual sectors, it is difficult to imagine broader efforts beyond individual services and programs. By exploring multisector efforts to prevent DV, the focus is shifted and more comprehensive changes to the community environment can be visualized. The Phase II analysis allows the approach to be expanded beyond individual sector strategies to envision entire communities that are intentionally designed to support safe relationships.

Multisector coalitions can include the healthcare sector, the housing/community development sectors, the business sector, social services sector, and others. The DV services sector plays an important bridge-building and leadership role. Many cities, and neighborhoods within those cities, have numerous multi-issue community coalitions focused on affordable housing, community development, health equity, and other related issues. Many cities and sometimes counties have existing multisector violence prevention coalitions and some have plans to address multiple forms of violence, including DV, community violence, and other forms of violence. Through the DVHCP project, numerous communities have existent partnership efforts focused on collaborative efforts to address DV within the health care and DV services settings. These partnerships could serve as the foundation for a broader coalition focused on addressing the community determinants of DV. Alternatively, DV and healthcare sector partners can participate in existing multisector prevention coalitions to address multiple issues, including DV.

For the purposes of this project, Prevention Institute completed a modified Phase II analysis to demonstrate what an initial analysis might entail. Sectors whose existing and potential efforts could lend well to effective multisector DV prevention were chosen: healthcare, social services, housing/community development, and DV services. As summarized in Diagram 6 (page 56), together, these sectors all have a strong voice and influence among their clients/constituents and within communities, and could bring together multiple sources of funding, data, and expertise. In doing so, this

multisector collaborative could engage community residents and adopt joint strategies such as co-locating health and DV services in affordable housing developments, adopting housing design that promotes norms of engagement in family matters and social cohesion, and creating a platform and method for data sharing across sectors. As well, these sectors can together amplify advocacy efforts for safe, stable, and affordable housing and jointly create and adopt organizational practices that promote strong community sanctions against DV. Ultimately, these joint strengths and strategies could lead to an increased availability of safe affordable housing for survivors of DV and other vulnerable families, greater social cohesion, healthier norms and culture, increased perceptions of safety, and decreased incidents of DV. Applying health equity principles to the analysis, Diagram 6 shows that multisector efforts must include the engagement of community residents and organizations, including DV survivors and organizations that represent DV survivors, in shaping priorities and directions.

Prevention Institute's THRIVE tool is also a valuable resource for supporting a health equity and multisector approach to DV prevention. While describing a full THRIVE process is beyond the scope of this paper, a basic description of the five-part process is included, as THRIVE can be used along with Collaboration Multiplier and other Prevention Institute tools to plan and implement a health equity and multisector approach to DV prevention:

1. *Engage and partner:* Identify and engage the support of key participants and decision-makers, including diverse members of the community.
2. *Foster shared understanding and commitment:* Cultivate a shared understanding of the community determinants of DV and foster buy-in for addressing them as an effective, equitable approach to promoting safe relationships and preventing DV.
3. *Assess:* Identify the assets and needs of the community with respect to the community determinants of DV.
4. *Plan and act:* Clarify vision, goals, and directives; establish decision-making processes and criteria; and implement multifaceted activities to achieve desired outcomes. This step often includes use of Prevention Institute's Collaboration Multiplier tool and Spectrum of Prevention tool (a strategy development tool to design multifaceted activities).
5. *Measure progress:* Ensure that communities use resources in the most effective, efficient manner and that efforts accomplish the desired outcomes.

Diagram 6: Collaboration Multiplier Phase II Grid

Sectors

Housing/ Community Development

Social Services

Joint Strengths

- Understanding of community culture from a strengths and resilience perspective
- Amplified voice and influence
- Multiple sources of funding and other resources
- Multiple sources and types of data
- Various areas of expertise, e.g. community culture, housing design, etc.

Shared Outcomes

- Increased availability of safe, stable, and affordable housing for vulnerable families
- Greater social cohesion
- Healthier norms and culture
- Decreased DV

Joint Strategies

- Advocate together for safe, stable, and affordable housing
- Adopt housing and building design elements that promote social inclusion and cohesion
- Adopt organizational practices to promote norms of engagement in family matters and strong community responses to DV
- Collect and share data about DV in the community, related risk and resilience factors, and the impact of joint actions

Sectors

DV Services

Healthcare

Engagement of Community Residents and Organizations, Including DV Survivors

Multisector Engagement to Transform the Physical/Built Environment and Socio-cultural Environment in Newport, Rhode Island

The Women's Resource Center (WRC), which serves Newport and Bristol Counties in Rhode Island, has recognized what research has shown – that increased social cohesion within a community is an important community determinant for DV prevention. They further realized that the physical conditions of a community have a strong influence on the ability of community members to engage with one another and to form successful and sustainable connections. With this understanding, the WRC initiated a mural project to transform a large graffiti covered retaining wall in a local park into a community designed work of art. Young people from the local high school captured their ideas of what makes Newport beautiful through a photo project and a team of professional artists transformed those photos into a collaborative piece of art. WRC took the lead in building partnerships across sectors, and successfully engaged residents as well as representatives from arts and culture, local media, community associations, and local government. Residents and members of these sectors all came together to support the project, and the supplies and stipends for the artists were paid for by local philanthropic organizations.

Residents of diverse ages and family structures came together to paint a mural that improved the physical conditions of a local park. The impact of these actions extended beyond improving the built environment and allowed the community to come together, form connections, and nurture a solid social foundation will protect against DV. One of the hired artists had a particular connection to the project, according to Jessica Walsh, Director of Prevention at the WRC. "A DV survivor ended up being hired as one of the artists. Afterward, she stood up at a public forum and said, without any prompting, that being involved with the mural project helped her to feel more connected within her community and that helped her to heal. Our efforts to increase social cohesion for DV prevention also helped her to rebuild her life and feel more connected."

Photo Source: Women's Resource Center of Rhode Island

Moving Forward

Toward a Health Equity and Multisector Approach to Preventing DV in California

Summary of Findings

This paper lays out a health equity and multisector approach to DV prevention in California that draws on the literature base, the expertise of over 30 key informants, and analysis conducted using several Prevention Institute tools and frameworks. It offers data and analysis to understand the determinants of DV and DV inequities, and the determinants of safe relationships. It identifies 13 sectors for DV prevention, including the DV services sector and public health sector as key leaders and bridge-builders, and opportunities for these sectors to influence community determinants. It also offers a methodology and suggestions for moving toward multisector actions that leverage joint assets/strengths toward joint strategies and greater impact. The four key findings from this research and analysis process are summarized and presented.

1. A health equity approach is a necessary and promising path forward for advancing DV prevention in California that is well aligned with the DV services sector's commitment to social justice.

Inequities exist in rates of DV as based on race, sex, socio-economic status, sexual orientation, gender identity, and other factors. There is a continuous and reciprocal interplay of factors within the environment, including structural drivers and community determinants that fundamentally contribute to DV and DV inequities. A health equity approach to DV prevention asserts that all people deserve to be safe in their relationships, and identifies strategies to counter the ways in which inequities in rates of DV are produced. A health equity approach is also guided by health equity principles, including the commitment to engaging community residents and organizations, including DV survivors and organizations that represent DV survivors, in shaping priorities and directions.

The DV services sector has strong roots in grassroots, social justice organizing, and a deep commitment to intersectionality – an approach to understanding and addressing interlocking systems of oppression based on race/ethnicity, socio-economic status, disability, sexual orientation, gender identity, and other factors. A health equity approach is well aligned with the DV movement's commitment to social justice and intersectionality.

2. The environment directly influences whether or not DV will occur, and the community environment represents an important, actionable place to promote safe relationships and a reduction in DV.

Structural drivers – the inequitable distribution of power, money, opportunity and resources – are a key determinant of inequity in rates of DV.[211] Structural drivers such as structural racism and socio-economic inequity play out at the community level to deeply impact community conditions. There are a number of interrelated factors in community environments – community determinants such as harmful norms and culture, lack of living wages and local wealth, and harmful media and ways of promoting products – where there is evidence of association with DV and DV inequities. There are also a number of interrelated factors where there is emerging evidence of association with safe relationships and a reduction in DV.

The community factors associated with DV and with a reduction in DV are interrelated. No one determinant alone can be attributed with causing or preventing DV; it is the accumulation of the community determinants of DV without compensatory community determinants of safe relationships that increase risk. Community violence and community trauma are overarching community factors that also shape the prevalence of DV and DV inequities and should be taken into account. Community environments represent an important, actionable place to promote safe relationships and reductions in DV. While strategies to address one factor at a time can be beneficial, strategies that address multiple factors in multiple environments can have greater impact.

3. Multiple sectors have important roles to play in preventing DV; there is emerging readiness for this approach.

A multisector approach offers concrete ways to influence the community environment, including the ways that structural drivers shape the community environment. Actions by multiple sectors

can decrease the community determinants of DV and DV inequities, and increase the community determinants of safe relationships. Analysis of the literature and interviews confirmed that 13 sectors have significant influence in shaping multiple community determinants by influencing where we live, work, connect and play, and receive care. For example, the housing/community development sectors and planning/zoning sectors can increase access to safe, stable and affordable housing, reduce alcohol outlet density, and decrease media and marketing practices that reinforce harmful norms and culture. These sectors can also improve the design of housing to increase open space, green space, and places for people to connect socially to strengthen social networks and trust. The business sectors can improve family and community economic security through living wages and implement organizational policies and practices to promote healthy norms and culture. The sports, entertainment, and faith sectors can influence community determinants such as norms and culture, social networks and trust, and community sanctions against DV. Within all sectors, actions can be taken to foster healthy norms and culture, social networks and trust, and strong community sanctions against DV. Multisector efforts to prevent DV can identify joint assets/strengths, potential shared outcomes, and potential joint strategies, to achieve greater impact toward entire communities that are intentionally designed to foster and support safe relationships. The DV services sector and the public health sector in particular can play important leadership and partnership building roles in multisector strategies.

4. There are particularly ripe opportunities to engage the healthcare, housing, and community development sectors in DV prevention, in partnership with other sectors.

In California, there are opportunities to build on existing DV services sector and healthcare sector partnerships to implement local health equity and multisector strategies. The growth of DV and healthcare partnerships through the DVHCP project presents a unique asset for the State. The healthcare sector as a whole, and the specific healthcare partners who have been engaged in addressing DV, have the potential to make great contributions toward DV prevention. By bridging prevention, population health, and healthcare, Prevention Institute's Community-Centered Health Homes (CCHH) model provides an emerging roadmap for

healthcare engagement in DV prevention. Building upon the patient-centered medical home model, a CCHH not only provides high quality health services while acknowledging that factors outside the healthcare system affect patient health outcomes, but actively participates in improving those factors.[212]

The Elements to Advance a Health Equity and Multisector Approach to DV Prevention

There is growing readiness and support for a health equity and multisector approach to DV prevention in California that builds on existing assets and efforts while exploring and developing new directions. The research, analysis, and frameworks offered in this paper provide an overall approach to moving this work forward at the state and local levels in California.

The following elements are needed to advance the approach in California:

1. **Leadership engagement**: Successful implementation of a health equity and multisector approach to DV prevention will require recognition of the value of this approach at the highest levels of leadership within the sectors to be engaged. Key innovators and champions within sectors who have insights and influence and who can prioritize and guide state and local strategy should be engaged. For example, leaders from professional associations, advocacy groups, and state governmental agencies, can inform the approach through understanding of strengths, needs, opportunities, and barriers. In engaging leadership, consideration should be given to representation from multiple generations, and diverse communities with respect to race/ethnicity, geography, and other factors.

2. **Partnership building**: A health equity and multisector approach depends on the collective, collaborative action of partners from different sectors and other stakeholders. Partnership building can improve the cultural fit and acceptance of new approaches, broaden reach, and improve coordination. Partnerships between organizations representing key sectors and stakeholders should be designed and developed as the basis for shared ownership, investment, and commitment to the success of DV prevention efforts in California. In particular, a health equity and multisector approach entails explicit bridge-building efforts between community leadership, including DV survivor leadership, and leadership from government sectors.

3. **Healthcare sector engagement:** Building on existing areas of engagement, the healthcare sector in California should be further engaged at the local and state levels to capitalize on the significant potential contributions by the sector. Prevention Institute's Community Centered Health Homes (CCHH) model can be used to guide local healthcare sector engagement. In some cases, existing DV and healthcare sector partners can act as conveners to bring together a community coalition focused on multisector DV prevention. In other cases, DV and healthcare sector partners can participate in existing multisector prevention coalitions. The CCHH model offers flexibility to implement strategies and activities that fit the degree of readiness of the healthcare organization and its partners. Further, communities can follow Prevention Institute's THRIVE five-part process (see Appendix C: Additional Resources, for a link to the THRIVE tool) to develop and implement a multi-faceted strategy and a specific local plan for implementation, evaluation, and sustainability. At the state level, interest and buy-in for the CCHH model can be cultivated, and a deeper understanding of interest and readiness can be assessed.

4. **Funding:** Funding is an important component of a health equity and multisector approach to DV prevention to bring in a renewed and bold commitment to innovation and outcome to meet the need and opportunity and fulfill California's potential. Funding is needed, for example, for implementation of local strategies through pilot projects. Funding is also needed to support state-level strategy development, implementation, and evaluation. At the same time, aligning the activities of multiple sectors with a DV prevention agenda utilizes existing resources to maximize outcomes.

5. **Communications/making the case:** Efforts are needed to articulate the need and opportunity for a health equity and multisector approach to DV prevention in California. Framing, messaging, and materials are needed to effectively communicate the core concepts and elements of the approach tailored to multiple stakeholders and audiences at the local and state levels to increase understanding and cultivate buy-in and investment. Communications collateral materials based on this report can also inform the development of funding proposals and training and capacity building efforts. For example, collateral materials should be developed to make the case for healthcare, housing,

and community development sector engagement in DV prevention, and identify specific roles and steps for these sectors to take action. **Local-level policy and practice:** A health equity and multisector approach to DV prevention can be implemented at the community level to influence community determinants through policy and practice change. Prevention Institute's THRIVE and Spectrum of Prevention can be used in local policy and practice strategy development. Using THRIVE, first, community partners can work to understand how community determinants increase the risk for DV in a community, which sectors need to be engaged in to influence these conditions, and where there is opportunity to make positive changes. After learning more about which specific community determinants most directly impact residence and what sectors can most effectively influence those determinants, a community coalition can advocate for, and engage in collaborative efforts to foster community environments that support safe relationships.

6. **State-level policy and practice:** State-level policy and practice is needed to support local efforts, including ongoing engagement of high level leadership among key sectors and partners at the state level; identification of state policy and practice changes that can create facilitative environments for local action; and, ongoing state-level communications activities to shape understanding and buy-in within key sectors.

7. **Training, capacity building, and cultivation of a community of practice:** Building individual and organizational understanding and capacity to address DV through a health equity and multisector approach is critical. There is also a need for training and capacity building across sectors to collaborate to advance community approaches, as well as skill-building specifically on multisector strategies. Training, capacity building and community of practice opportunities can be offered to stakeholders throughout California representing the sectors identified in this paper.

8. **Evaluation and continuous quality improvement:** To ensure that progress in advancing a health equity and multisector approach to DV prevention is assessed, and that learning, course corrections, and adaptations are made in real-time, attention should be given to data, evaluation, and continuous quality improvement. In particular, a health equity multisector approach involves tracking both data related to community determinants at the population level, as well as disaggregated data by race, gender, age, and other factors.

Immediate Next Steps

To move a health equity and multisector approach to DV prevention in California forward, the following actions can be taken: 1) engagement of an Advisory Group; 2) development of a theory of change and logic model; 3) and, design of program components (which are the elements to advance a health equity and multisector approach to DV prevention, outlined beginning on page 61). After these steps, a program to support state and local prevention efforts can be implemented and evaluated with continuous feedback and improvement. Immediately, the following next steps can be taken:

- A health equity and multisector approach to DV prevention in California should be further elaborated and strengthened with the insights and expertise of additional stakeholders and audiences throughout the state through an Advisory Group. The Advisory Group can include state and local representatives from key sectors identified in this paper, as well as additional experts/advocates addressing health equity, sexual violence, community violence, and community trauma.
- Develop initial communications collateral material to increase understanding and cultivate buy-in and investment among key stakeholders and sectors, and disseminate through e-alerts, blog/website posts, presentations at conferences and meetings, and other means.
- With ongoing input from the Advisory Group, a theory of change and logic model can be developed, and program components consistent with the theory of change and logic model should be designed. Program components are delineated as the elements to advance a health equity and multisector approach to DV prevention, outlined beginning on page 61.
- Communities with interest and readiness to engage in a health equity and multisector approach to DV prevention should be identified. Cities/counties with existing multisector violence prevention coalitions and violence prevention plans, existing Domestic Violence and Healthcare Partnership sites, and existing multi-issue community coalitions focused on affordable housing, community development, health equity, and other related issues, are potential implementation vehicles.
- Training materials should be developed initially for early adopters to build understanding of a health equity and multisector approach to DV prevention and initial trainings should be conducted to begin to build capacity and to cultivate an early adopters' community of practice.

APPENDIX A: GLOSSARY OF TERMS

Community determinants:
Community determinants, or community conditions, are the determinants of health at the community level. They constitute the socio-cultural, physical/build and educational/economic community environments, including factors such as education, employment, housing, what's sold and how it's promoted, arts and cultural expression, social connection and trust, and transportation. Community determinants are shaped by structural drivers and reflect unequal opportunities, choices, and access to resources that would allow people to pursue healthy, thriving lives.

Community trauma:
Community trauma is the cumulative and synergistic impact of interpersonal violence, historical and intergenerational violence, and exposure to the impact of structural drivers of inequity.

Community violence:
Intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim. It is characterized by its shared widespread impact and cyclical nature within the community.

Domestic violence, or intimate partner violence:
Physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner. An intimate partner is a person with whom one has a close personal relationship that can be characterized by: emotional connectedness, regular contact, ongoing physical contact and/or sexual behavior, identity as a couple, and/or familiarity and knowledge about each other's lives.[213] The term domestic violence is used in this paper, rather than intimate partner violence, as it's currently the most recognized and widely used term in California.

Health equity:
Means that every person, regardless of who they are – the color of their skin, their level of education, their gender or sexual identity, whether or not they have a disability, the job that they have, or the neighborhood that they live in – has an equal opportunity to achieve optimal health.[214]

APPENDIX A: GLOSSARY OF TERMS

Resilience factors:
Conditions or characteristics in individuals, families, communities and society that are protective, thus reducing the likelihood that violence will occur, even in the presence of risk factors. Effective violence prevention efforts reduce risk factors and strengthen resilience factors.

Risk factors:
Conditions or characteristics in individuals, families, communities and society that increase the likelihood that violence will occur. No one factor alone can be attributed with causing or preventing violence; it is the accumulation of risk factors without compensatory resilience factors that puts individuals, families and communities at risk.

Sector:
A field, discipline, or area of expertise that is characterized by a combination of related activities and functions that are typically understood as distinct from those of others.

Structural drivers:
Sometimes referred to as structural determinants, are the distribution of power, money, and other resources nationally and globally that, "together fashion the way societies are organized." Structural drivers include economic and social policies, and processes and norms, particularly at the national and international levels, that reflect historic and present day systems of inequality, such as racism, classism, sexism and heterosexism. [215] [216] [217]

Structural violence:
Harm that individuals, families and communities experience from economic and social structures and institutions and relations of power, privilege and inequality; and, inequities that may harm people by preventing them from meeting their basic needs.[218]

APPENDIX B: HEALTH EQUITY PRINCIPLES

These principles were adapted from Alameda County Public Health Department's Life and Death From Unnatural Causes: Health and Social Inequity in Alameda County (2008) and featured in Prevention Institute's A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety (2009), commissioned by the Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

- Understand and account for the *historical forces* that have left a legacy of racism, sexism, and other forms of oppression.
- Acknowledge the *cumulative impact of stressful experiences and environments*. For some families, poverty lasts a lifetime and even crosses generations, leaving family members with few opportunities to make healthful decisions. Continued exposure to oppression may in and of itself exert a great toll on both physical and mental health.
- Recognize the *role of privilege* in contributing to disparities in health outcomes and acknowledge that policies have afforded privilege to some groups at the expense of others.
- *Encourage meaningful public participation* with attention to outreach, follow-through, language, inclusion, and cultural understanding. Government and private funding agencies should actively support efforts to build resident capacity for civic engagement.
- Adopt an overall approach that recognizes the cumulative impact of multiple stressors and focuses on *changing community conditions,* not blaming individuals or groups for their disadvantaged status.
- Strengthen the *social fabric of neighborhoods*. Residents need to be connected and supported and to feel empowered to improve the safety and well-being of their families. All residents need a sense of belonging, dignity, and hope.

APPENDIX B: HEALTH EQUITY PRINCIPLES

- Promote equity solutions that address urgent survival issues for people and people of color with low average incomes, while simultaneously responding to *national and international concerns*, such as the global economy, climate change, U.S. foreign policy, and immigration reform.
- Address the developmental needs and transitions of *all age groups*. While infants, children, youth, adults, and elderly require age-appropriate strategies, the largest investments should be in early childhood, which establishes the foundation for adult health.
- *Work across multiple sectors* of government and society in order to make the necessary structural changes. Such work should be in partnership with community advocacy groups that continue to pursue a more equitable society.
- *Measure and monitor the impact of social policy* on health and safety to ensure equity goals are being accomplished. Institute systems to track governmental spending by neighborhood. Monitor changes in health equity over time and place to help identify the impact of adverse policies and practices.
- *Enable groups heavily impacted by inequities to have a voice* in identifying helpful policies and in holding government accountable for implementing them.
- Recognize that eliminating inequities provides a huge *opportunity to invest in community.* Inequity among us is not acceptable, and we all stand to gain by eliminating it.
- Efforts should build on the *strengths and assets* of communities, recognizing that communities are resilient and have a strong history of making change.

APPENDIX C: ADDITIONAL RESOURCES

Prevention Institute tools

Two Steps to Prevention is a tool that presents a systematic way of first looking at adverse injury and illness, then at the exposures and behaviors that affect these outcomes, and then at the environment that shapes patterns of exposure and behavior or directly influences the onset of injury and illness.

THRIVE is a framework for understanding how structural drivers play out at the community level to impact the sociocultural, physical/built, and economic/educational environments. THRIVE is also a tool for engaging community members and practitioners in assessing the status of community determinants, prioritizing them, and taking action to change them to improve health, safety, and health equity.

Collaboration Multiplier is an interactive framework and tool for analyzing collaborative efforts across fields. It is designed to guide an organization to a better understanding of which partners it needs and how to engage them, or to facilitate organizations that already work together in identifying activities to achieve a common goal, identify missing sectors that can contribute to a solution, delineate partner perspectives and contributions, and leverage expertise and resources.

Spectrum of Prevention helps expand prevention efforts beyond education models by promoting a multifaceted range of activities for effective prevention. It has been used nationally in prevention initiatives addressing a wide range of health and safety issues.

Community-Centered Health Homes model provides a concrete framework for institutionalizing practices that help advance population health by addressing community conditions that impact health outcomes. A CCHH not only acknowledges that factors outside the healthcare system affect patient health outcomes, it actively participates in improving them to achieve health equity.

APPENDIX C: ADDITIONAL RESOURCES

Prevention Institute papers and briefs

Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma offers a groundbreaking framework for understanding the relationship between community trauma and violence. Based on interviews with practitioners in communities with high rates of violence, the report outlines specific strategies to address and prevent community trauma and foster resilience.

Poised for Prevention: Advancing Promising Approaches to Primary Prevention of Intimate Partner Violence discusses primary prevention of intimate partner violence (IPV) and promising approaches to environmental/norms change. The report also includes an examination of IPV primary prevention within immigrant communities.

Multisector Partnerships for Preventing Violence is a comprehensive guidebook that details roles and contributions for multiple sectors in preventing violence, provides examples from what's working around the country, and informs effective collaboration across key sectors. *A Multisector Approach to Preventing Violence* is a companion overview document, which outlines the approach.

Safety in All Policies: A Brief to Advance Multisector Actions for a Safer California lays out the five core elements of Safety in All Policies, an approach to promoting a common vision and shared priority for safety across multiple sectors. It is designed as a roadmap for state governmental entities to assist them in promoting policies, practices, and actions in support of safe communities.

Safety in All Policies: A Brief on Engaging the Housing and Community Development Sector in Preventing Violence in California focuses on the housing and community development sector and describes seven recommended actions at the local level, as well as potential roles for the state legislature and the California Business, Consumer Services, and Housing Agency in support of local efforts.

Community-Centered Health Homes Model Fact Sheet addresses basic questions about the CCHH model, including what a CCHH is, why healthcare organizations should consider implementing the model, and what we've learned from pilot sites across the country.

APPENDIX D: REFERENCES

1. Prevention Institute; Alameda County Public Health Department. (2009). A time of opportunity: local solutions to reduce inequities in health and safety.

2. Braveman, P.A., Kumanyika, S., Fielding, J., Laveist, T., Borrell, L., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: The issue is justice. *American Journal of Public Health, 101*, 149-155.

3. Adewunmi, B. (2014, Apr 2). Kimberlé Crenshaw on intersectionality: "I wanted to come up with an everyday metaphor that anyone could use"

4. NoVo Foundation. (2016). Movement Building Practice: Margins to Center.

5. Prentice, B. (2014). Expanding the Boundaries: Health Equity and Public Health Practice (Rep.).

6. Braveman, P. A., Kumanyika, S., Fielding, J., Laveist, T., Borrell, L., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: The issue is justice. *American Journal of Public Health,* 101, 149-155.

7. Prentice, B. (2014). Expanding the Boundaries: Health Equity and Public Health Practice (Rep.).

8. Bauer, G. R. (2014). Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. *Social Science & Medicine*, 110, 10-17.

9. Lee,D. (2015, Sept. 30). Informational Interview [Telephone interview].

10. Zahnd, E., Aydin, M., Grant, D., & Holtby, S. (2011). The Link Between Intimate Partner Violence, Substance Abuse and Mental Health in California (Issue brief). Los Angeles, CA: UCLA Center for Health Policy Research.

11. U.S. Census Bureau. (2015, July 24). Population in the United States: Los Angeles, CA.

12. Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). 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.

13. Catalano, S.M. (2012). Intimate Partner Violence, 1993-2010.

14. Catalano, S.M. (2007). Intimate Partner Violence in the United States.

15. Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). 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.

16. Catalano, S.M., Smith, E., Snyder, H., & Rand, M. (2009) Female Victims of Violence.

17. Indian Law Resource Center. Ending Violence Against Native Women.

18. Zahnd, E., Aydin, M., Grant, D., & Holtby, S., (2011) The Link Between Intimate Partner Violence, Substance Abuse and Mental Health in California (Issue brief). Los Angeles, CA: UCLA Center for Health Policy Research.

19. Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). 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.

20. Boutrous, H., Siebert, E., Giang, M., Johnston, C., & Shealy, S. (2015). The Report on the Status of Women and Girls in California (Rep.). Los Angeles, CA: Mount Saint Mary's University in Los Angeles.

21. Catalano, S.M. (2007). Intimate Partner Violence in the United States.

22. Walters, M.L., Chen J., & Breiding, M.J. (2013). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on Victimization by Sexual Orientation. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

23. Zahnd, E., Grant, D., Aydin, M., Chia, Y., & Padilla-Frausto, D. (2010). Nearly Four Million California Adults Are Victims of Intimate Partner Violence (Issue brief). Los Angeles, CA: UCLA Center for Health Policy Research.

24. Center for Disease Control and Prevention. (2015). *Intimate Partner Violence: Risk and Protective Factors*.

25. Center for Disease Control and Prevention. (2015) Strategic Direction for Intimate Partner Violence Prevention.

26. The California Partnership to End Domestic Violence [Cal Part]. (2015, Oct. 6). *The Cultural Shift We Need to End Domestic Violence* [Video file].

27. Commission on Social Determinants of Health (CSDH), World Health Organization (WHO). (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Final report of the CSDH. Geneva: World Health Organization.

28. Commission on Social Determinants of Health (CSDH), World Health Organization (WHO). (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Final report of the CSDH. Geneva: World Health Organization.

29. House JS, and Williams DR. Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health. In: Promoting Health: Intervention Strategies from Social and Behavioral Research. Washington DC: Institute of Medicine/ National Academy Press; 2000: 81-124.

30. Bancroft, P. (2015, Sep. 23). Informational Interview [Telephone interview].

31. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Prevention Institute, Oakland, CA.

32. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

33. Bunch, T. (2015, Sept. 30). Informational Interview [Telephone interview].

34. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

35. Santana, M.C., Raj, A., Decker, M.R., La Marche, A., & Silverman, J.G. (2006). Masculine gender roles associated with increased sexual risk and intimate partner violence perpetration among young adult men. *Journal of Urban Health, 83*(4), 575-585.

36. World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva, World Health Organization.

37. True Child. *Gender Norms: A Key to Combating Gender-Based Violence Among At-Risk Youth*. Fact Sheet. Washington D.C.: True Child.

38. World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva, World Health Organization.

39. Centers for Disease Control. (2008). Intimate partner violence: Risk and protective factors. Retrieved March, 23, 2009.

40. World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva, World Health Organization.

41. Santana, M.C., Raj, A., Decker, M.R., La Marche, A., & Silverman, J.G. (2006). Masculine gender roles associated with increased sexual risk and intimate partner violence perpetration among young adult men. *Journal of Urban Health, 83*(4), 575-585

42. Center for Disease Control and Prevention. (2015). *Intimate Partner Violence: Risk and Protective Factors*.

43. Santana, M.C., Raj, A., Decker, M.R., La Marche, A., & Silverman, J.G. (2006). Masculine gender roles associated with increased sexual risk and intimate partner violence perpetration among young adult men. *Journal of Urban Health, 83*(4), 575-585.

44. Vanderende, K.E., Yount, K.M., Dynes, M.M., & Sibley, L.M. (2012). Community-level correlates of intimate partner violence against women globally: A systematic review. *Social Science & Medicine, 75*(7), 1143-1155.

45. World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva, World Health Organization.

46. Krug, E.G., et.al., eds. (2002). *World Report on Violence and Health*. Geneva: World Health Organization.

47. Pinchevsky, G. M., & Wright, E. M. (2012). The impact of neighborhoods on intimate partner violence and victimization. *Trauma, Violence, & Abuse, 13*(2), 112-132.

48. Heise, L. (1998). Violence Against Women: An Integrated Ecological Framework. *Violence Against Women, 4*(262).

49. World Health Organization &London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*. Geneva: World Health Organization.

50. Vanderende, K.E., Yount, K.M., Dynes, M.M., & Sibley, L.M. (2012). Community-level correlates of intimate partner violence against women globally: A systematic review. *Social Science & Medicine, 75*(7), 1143-1155.

51. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

52. Center for Disease Control and Prevention. (2015). *Intimate Partner Violence: Risk and Protective Factors*.

53. Zolotor, A.J., & Runyan, D.K. (2006). Social capital, family violence, and neglect. *Pediatrics*, 117(6), 1124-31.

54. Center for Disease Control and Prevention. (2015). *Intimate Partner Violence: Risk and Protective Factors*.

55. Farris, C.A., & Fenaughty, A.M. (2002). Social isolation and domestic violence among female drug users. *The American Journal of Drug and Alcohol Abuse*, 28(2), 339-351.

56. Beyer, K., Wallis, A.B., & Hamberger, L.K. (2015). Neighborhood environment and intimate partner violence: A systematic review. *Trauma, Violence & Abuse, 16*(1), 16-47.

57. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

58. World Health Organization &London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva: World Health Organization

59. Beyer, K., Wallis, A.B., & Hamberger, L K. (2015). Neighborhood environment and intimate partner violence: A systematic review. *Trauma, Violence & Abuse, 16*(1),16-47.

60. World Health Organization & London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*. Geneva: World Health Organization.

61. Rothman, E. (2015, Sept. 24). Informational Interview [Telephone interview].

62. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

63. Malamuth, N.M., Addison, T., & Koss, M. (2000). Pornography and sexual aggression: Are there reliable effects and can we understand them? *Annual Review of Sex Research, 11*(1), 26-91.

64. Flood, M., & Pease, B. (2009). Factors influencing attitudes to violence against women. *Trauma, Violence & Abuse, 10*(2), 125-142.

65. Miranda, A., Horvath, L., Massey, K., Pina, A., Scally, M., & Adler, J. R. (n.d.). "Basically... porn is everywhere": A Rapid Evidence Assessment on the Effects that Access and Exposure to Pornography has on Children and Young People (Rep.). London: Office of the Children's Commissioner.

66. Lanz, P. M., Corella, M. A., & Uribe, C. S. (2013). Factors Associated with the Use of Video Games: Aggression, Domestic Violence, and Depression. *Journal of Modern Education Review, 3*(3), 207-214.

67. Capella, M.L., Hill, R.P., Rapp, J.M., & Kees, J. (2010). The impact of violence against women in advertisements. *Journal of Advertising, 39*(4), 37-52.

68. Alaniz, M.L. (2013). Sexual Violence, Alcohol, and Advertising. In R.N. Parker & K.J. McCaffree (Eds.), *Alcohol and violence: The nature of the relationship and the promise of prevention* (pp. 39-60). Lanham, MD: Lexington Books.

69. Cunradi, C. B., Mair, C., Ponicki, W., & Remer, L. (2011). Alcohol Outlets, Neighborhood Characteristics, and Intimate Partner Violence: Ecological Analysis of a California City. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 88(2), 191–200.

70. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

71. Mack, R. (1997). Bringing down the walls of state pre-emption: California Cities Fight for Local Control of Alcohol Outlets. *The Berkeley Journal of African-American Law & Policy, 3*(1), 295-324.

72. Cunradi, C. B., Mair, C., Ponicki, W. and Remer, L. (2012), Alcohol Outlet Density and Intimate Partner Violence-Related Emergency Department Visits. *Alcoholism: Clinical and Experimental Research*, 36, 847–853.

73. Livingston, M. (2011). A longitudinal analysis of alcohol outlet density and domestic violence. *Addiction, 106*(5), 919-925.

74. Kearns, M. C., Reidy, D. E., & Valle, L. A. (2015). The role of alcohol policies in preventing intimate partner violence: a review of the literature. *Journal of Studies on Alcohol and Drugs, 76*(1), 21-30.

75. John Hopkins Center to Eliminate Cardiovascular Health Disparities. (2016). Stable Housing.

76. McKinney, C. M., Caetano, R., Harris, T. R., & Ebama, M. S. (2009). Alcohol availability and intimate partner violence among U.S. couples. *Alcoholism: Clinical and Experimental Research, 33*(1), 169-176.

77. Heise, L. (1998). Violence Against Women: An Integrated Ecological Framework. *Violence Against Women, 4*(262).

78. Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The Lancet, 360*(9339), 1083-1088.

79. Pavao, J., Alvarez, J., Baumrind, N., Induni, M., & Kimerling, R. (2007). Intimate Partner Violence and Housing Instability. *American Journal of Preventive Medicine, 32*(2), 143-146.

80. Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). *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.

81. Pavao, J., Alvarez, J., Baumrind, N., Induni, M., & Kimerling, R. (2007). Intimate Partner Violence and Housing Instability. *American Journal of Preventive Medicine, 32*(2), 143-146.

82. Stoops, N. (n.d.). Speech presented at National Alliance to End Homelessness Conference, Los Angeles.

83. John Hopkins Center to Eliminate Cardiovascular Health Disparities. (2016). Stable Housing.

84. Kim, H., Grogan-Kaylor, A., Han, Y., Maurizi, L., & Delva, J. (2013). The Association of Neighborhood Characteristics and Domestic Violence in Santiago, Chile. *Journal of Urban Health : Bulletin of the New York Academy of Medicine, 90*(1), 41–55.

85. Temkin, K., & Rohe, W. M. (1998). Social capital and neighborhood stability: An empirical investigation. *Housing Policy Debate, 9*(1), 61-88.

86. Melbin, A. (2015, Sept. 24). Informational Interview [Telephone interview].

87. Browning, C. R. (2002). The span of collective efficacy: Extending social disorganization theory to partner violence. *Journal of Marriage and Family, 64*(4), 833-850.

88. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

89. World Health Organization & London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva: World Health Organization.

90. Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A Systematic Review of Risk Factors for Intimate Partner Violence. *Partner Abuse, 3*(2), 231-280.

91. Miles-Doan, R. (1998). Violence between spouses and intimates: Does neighborhood context matter? *Social Forces, 77*(2), 623-645.

92. Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A Systematic Review of Risk Factors for Intimate Partner Violence. *Partner Abuse, 3*(2), 231-280.

93. Heise, L. (1998). Violence Against Women: An Integrated Ecological Framework. *Violence Against Women, 4*(262).

94. Benson, M. L., Fox, G. L., DeMaris, A., & Van Wyk, J. (2003). Neighborhood disadvantage, individual economic distress and violence against women in intimate relationships. *Journal of Quantitative Criminology, 19*(3), 207-235.

95. Beyer, K., Wallis, A. B., & Hamberger, L. K. (2015). Neighborhood environment and intimate partner violence: A systematic review. *Trauma, Violence & Abuse, 16*(1), 16-47.

96. Benson, M. L., Fox, G. L., DeMaris, A., & Van Wyk, J. (2003). Neighborhood disadvantage, individual economic distress and violence against women in intimate relationships. *Journal of Quantitative Criminology, 19*(3), 207-235.

97. Payne, J. (2015, Nov. 2). Informational Interview [Telephone interview].

98. *Community Violence | National Child Traumatic Stress Network - Child Trauma Home*. *National Child Traumatic Stress Network*.

99. Beyer, K., Wallis, A. B., & Hamberger, L. K. (2015). Neighborhood environment and intimate partner violence: A systematic review. *Trauma, Violence & Abuse, 16*(1), 16-47.

100. Miles-Doan, R. (1998). Violence between spouses and intimates: Does neighborhood context matter? *Social Forces, 77*(2), 623-645.

101. Reed, E., Silverman, J. G., Welles, S. L., Santana, M. C., Missmer, S. A., & Raj, A. (2009). Associations between perceptions and involvement in neighborhood violence and intimate partner violence perpetration among urban, African American men. *Journal of Community Health, 34*(4), 328-335.

102. Benson, M. L., Fox, G. L., DeMaris, A., & Van Wyk, J. (2003). Neighborhood disadvantage, individual economic distress and violence against women in intimate relationships. *Journal of Quantitative Criminology, 19*(3), 207-235.

103. Raghavan, C., Mennerich, A., Sexton, E., & James, S. E. (2006). Community violence and its direct, indirect, and mediating effects on intimate partner violence. *Violence Against Women, 12*(12), 1132-1149.

104. Pinderhughes, H., Davis, R., Williams, M. (2015) Adverse Community Experiences and Resilience: A framework for addressing and preventing community-level trauma. Oakland: Prevention Institute.

105. Oetzel, J., & Duran, B. (2004). Intimate partner violence in American Indian and/or Alaska Native communities: A social ecological framework of determinants and interventions. *American Indian and Alaska Native Mental Health Research, 11*(3), 49 - 68.

106. Rothman, E. (2015, Sept. 24). Informational Interview [Telephone interview].

107. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

108. *Promoting respectful, nonviolent intimate partner relationships through individual, community, and societal change*. (2008). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

109. *Promoting respectful, nonviolent intimate partner relationships through individual, community, and societal change*. (2008). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

110. *Promoting respectful, nonviolent intimate partner relationships through individual, community, and societal change*. (2008). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

111. Banyard, V. L. (2015). *Toward the next generation of bystander prevention of sexual and relationship violence: action coils to engage communities*. Springer International Publishing.

112. Yeakle, C. (2015, Sept. 21). Informational Interview [Telephone interview].

113. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

114. Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A Systematic Review of Risk Factors for Intimate Partner Violence. *Partner Abuse, 3*(2), 231-280.

115. Zolotor, A. J., & Runyan, D. K. (2006). Social capital, family violence, and neglect. *Pediatrics, 117*(6), e1124-31.

116. Vanderende, K. E., Yount, K. M., Dynes, M. M., & Sibley, L. M. (2012). Community-level correlates of intimate partner violence against women globally: A systematic review. *Social Science & Medicine, 75*(7), 1143-1155.

117. Heise, L. (1998). Violence Against Women: An Integrated Ecological Framework. *Violence Against Women, 4*(262).

118. Beyer, K., Wallis, A. B., & Hamberger, L. K. (2015). Neighborhood environment and intimate partner violence: A systematic review. *Trauma, Violence & Abuse, 16*(1), 16-47.

119. Center for Disease Control and Prevention. (2015). *Intimate Partner Violence: Risk and Protective Factors*.

120. Center for Disease Control and Prevention. (2017). The DELTA FOCUS Program: Intimate Partner Violence is Preventable.

121. Vanderende, K. E., Yount, K. M., Dynes, M. M., & Sibley, L. M. (2012). Community-level correlates of intimate partner violence against women globally: A systematic review. *Social Science & Medicine, 75*(7), 1143-1155.

122. Browning, C. R. (2002). The span of collective efficacy: Extending social disorganization theory to partner violence. *Journal of Marriage and Family, 64*(4), 833-850.

123. Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A Systematic Review of Risk Factors for Intimate Partner Violence. *Partner Abuse, 3*(2), 231-280.

124. Casey, E. A., & Beadnell, B. (2010). The structure of male adolescent peer networks and risk for intimate partner violence perpetration: Findings from a national sample. *Journal of Youth and Adolescence*, 39(6), 620-633.

125. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

126. Center for Disease Control and Prevention. (2013). *Healthy Places - Social Capital*.

127. Harvey, A., Garcia-Moreno, C., & Butchart, A. (2007). *Primary prevention of intimate-partner violence and sexual violence: Background paper for WHO expert meeting May 2–3, 2007* (Rep.). Geneva: World Health Organization.

128. World Health Organization & London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva: World Health Organization.

129. Pinchevsky, G. M., & Wright, E. M. (2012). The impact of neighborhoods on intimate partner violence and victimization. *Trauma, Violence, & Abuse, 13*(2), 112-132.

130. World Health Organization & London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva: World Health Organization.

131. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

132. Cunradi, C. B., Mair, C., Ponicki, W., & Remer, L. (2011). Alcohol Outlets, Neighborhood Characteristics, and Intimate Partner Violence: Ecological Analysis of a California City. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 88*(2), 191–200.

133. Kearns, M. C., Reidy, D. E., & Valle, L. A. (2015). The role of alcohol policies in preventing intimate partner violence: a review of the literature. *Journal of Studies on Alcohol and Drugs, 76*(1), 21-30.

134. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

135. Raphael, J. (2001). Public housing and domestic violence. *Violence Against Women, 7*(6), 699-706.

136. Kuo, F. E., & Sullivan, W. C. (2001). Environment and crime in the inner city: Does vegetation reduce crime? *Environment and Behavior, 33*(3), 343–367.

137. Donovan, G. H., & Prestemon, J. P. (2010). The effect of trees on crime in Portland, Oregon. *Environment and Behavior, 44*(3).

138. Prevention Institute. (2015). *Community Safety by Design: Preventing violence through land use*. Oakland, CA: Prevention Institute.

139. Cohen, D. A., Inagami, S., & Finch, B. (2008). The built environment and collective efficacy. *Health & Place, 14*(2), 198-208.

140. Branas, C. C., Cheney, R. A., MacDonald, J. M., Tam, V. W., Jackson, T. D., & Ten Have, T. R. (2011). A difference-in-differences analysis of health, safety, and greening vacant urban space. *American Journal of Epidemiology, 174*(11), 1296-1306.

141. Prevention Institute. (2015). *Making the case with THRIVE: Background research on the community determinants of health*. Oakland, CA: Prevention Institute.

142. Vyas, S., & Watts C. (2009). How does economic empowerment affect women's risk of intimate partner violence in low- and middle-income countries? a systematic review of published evidence. *Journal of International Development, 21*(5), 577–602.

143. Pinderhughes, H., Davis, R., Williams, M. (2015). Adverse community experiences and resilience: A framework for addressing and preventing community-level trauma. Oakland: Prevention Institute.

144. Pinderhughes, H., Davis, R., Williams, M. (2015). Adverse community experiences and resilience: A framework for addressing and preventing community-level trauma. Oakland: Prevention Institute.

145. Melbin, A., Jordan, A. & Smyth, K.F. (2014, Oct.). *How do survivors define success?: A new project to address an overlooked question*. Greenfield, MA: Full Frame Initiative.

146. Payne, J. (2015, Nov. 2). Informational Interview [Telephone interview].

147. U.S. Department of Health and Human Services. (2015). *Strategic Goal 1*.

148. American Public Health Association. (n.d.). What is Public Health?

149. Roller, S. (2015, Oct. 10). Informational Interview [Telephone interview].

150. Dayton, L. (2016, Mar. 28). Housing a crucial, missing link for women escaping domestic violence.

151. AB418. Assemb. Reg. Sess. 2015-2016. (CA. 2015).

152. California Planning Roundtable. (2015.) The Social Determinants of Health for Planners: Live, Work, Play, Learn! Los Angeles, CA: California Planning Rountable.

153. Altshuler, B. (2015, Nov. 6). Informational Interview [Telephone interview].

154. Taylor, B., Stein, N., Woods, D., & Mumford, E. (2011). *Shifting Boundaries: Final report on an experimental evaluation of a youth dating violence prevention program in New York City Middle Schools*. Washington D.C.: Police Executive Research Forum.

155. Prevention Institute. (2015). *Community Safety by Design: Preventing violence through land use*. Oakland, CA: Prevention Institute.

156. Browning, C. R. (2002). The span of collective efficacy: Extending social disorganization theory to partner violence. *Journal of Marriage and Family, 64*(4), 833-850.

157. Levine, D. (2016, Feb. 19). Informational Interview.

158. HOPE SF. *About HOPE SF*. (2016).

159. Adeeyo, S. (2015). *Without access to resources, neighborhood public health interventions are limited*. *Urban Institute*.

160. Adeeyo, S. (2015). *Without access to resources, neighborhood public health interventions are limited*. *Urban Institute*.

161. Rawlings-Blake, S., & Stosur, T. (2013). *City Council Bill #12 - 0152 TransForm Baltimore – Zoning Alcohol Outlet Reduction*. Presentation.

162. Cassidy, J. (2015, Nov. 6). Informational Interview [Telephone interview].

163. Levine, D. (2016, Feb. 19). Informational Interview.

164. Linda, S., Lisa, K., & Polanco, A. (2015, Dec. 8). Informational Interview [Telephone Interview].

165. Springer, S. (2015, Jul. 31). *UNAC/UHCP Stands Up for Stronger Workplace Violence Prevention Standards*.

166. Cassidy, J. (2015, Nov. 6). Informational Interview [Telephone interview].

167. Gartland, D., Hemphill, S. A., Hegarty, K., & Brown, S. J. (2011). Intimate partner violence during pregnancy and the first year postpartum in an Australian pregnancy cohort study. *Maternal and Child Health Journal, 15*(5), 570-578.

168. Linda, S., Lisa, K., & Polanco, A. (2015, Dec. 8). Informational Interview [Telephone Interview].

169. Futures Without Violence. (2016). *Low Wage High Risk Pilot Site Project*.

170. Linda, S., Lisa, K., Gutierrez, W., & Polanco, A. (2015, December, 8). Informational Interview [Telephone Interview].

171. Job Corps Health and Wellness Program. (2016). *Sexual Assault Prevention*.

172. Primrose, E. (2012). Job Corps' Commitment to Preventing Intimate Partner Violence. *U.S. Department of Labor Blog*.

173. Bagnato, N. (2015, Jul. 27). Informational Interview [Telephone interview].

174. The value of hosting a mega sports event as a social, economic, and environmental sustainable development tool. (2016, Feb. 16).

175. Refuse To Abuse® – Washington State Coalition Against Domestic Violence (WSCADV). (n.d.).

176. A Call To Men. (n.d.).

177. Bunch, T. (2015, Sept. 30). Informational Interview [Telephone interview].

178. One in spirit: Domestic violence advocates and faith and spiritual leaders working in partnership to end domestic violence (Rep.). (2010). Transforming Communities Technical Assistance, Training Resource Center.

179. Miller, E. (2015, Sept. 30). Informational Interview [Telephone interview].

180. Centers for Disease Control and Prevention (CDC). (2003). *Costs of intimate partner violence against women in the United States*. Atlanta, GA: CDC, National Center for Injury Prevention and Control.

181. Pañares, R., Butler, D., Mikkelson, L. (2014). *Assessing and promoting the adoption of the community centered health homes model: Findings from California*. Prevention Institute, Oakland, CA.

182. James, L. (2015, Nov. 2). Informational Interview [Telephone interview].

183. Pañares R, Mikkelsen L, Do R. (2016). *The Community-Centered Health Home Model: Updates and Learnings*. Oakland, CA: Prevention Institute.

184. Miller, E. (2015, Sept. 30). Informational Interview [Telephone interview].

185. Magoon, P.M. (2016) Wednesday letters: Jackson right about what's wrong with GOP.

186. Catholic Health Initiatives United Against Violence. (2015). *Five Year Progress Report: Community Based Violence Prevention Initiatives 2010-2015*.

187. Catholic Health Initiatives United Against Violence. (2015). *Five Year Progress Report: Community Based Violence Prevention Initiatives 2010-2015*.

188. Catholic Health Initiatives United Against Violence. (2015). *Five Year Progress Report: Community Based Violence Prevention Initiatives 2010-2015*.

189. City of New Orleans. (2014). Mayor Landrieu Announces Economic Opportunity Strategy for Disadvantaged Job Seekers and Businesses.

190. PolicyLink. (2014). Connecting Black Men to Jobs in New Orleans's Anchor Institutions.

191. City of New Orleans. (2017). Mayor Landrieu Honors Businesses for Creating Job Opportunities, Partnership with Economic Opportunity Strategy.

192. Futures Without Violence. (2016). Domestic Violence Health Care Partnership.

193. James, L. (2015, Nov. 2). Informational Interview [Telephone interview].

194. Flynn, D. (2011). Baby Makes 3: Project Report (Rep.). Victoria, Australia: Whitehorse Community Health Services.

195. Raj A., Dasgupta A., Goldson I., Lafontant D., Freeman E., Silverman JG. (2014). Pilot evaluation of the Making Employment Needs [MEN] Count intervention: Addressing behavioral and structural HIV risks in heterosexual black men. *AIDS Care, 26*(2):152-159.

196. Merrill, J. (n.d.). Why we can't ignore the link between mass shootings & domestic violence.

197. Melbin, A., Jordan, A. & Smyth, K.F. (2014). How do survivors define success?: A new project to address an overlooked question. Greenfield, MA: Full Frame Initiative.

198. Mercy, J. A., & Freire, K. E. (2015). DELTA PREP building capacity to meet the public health urgency of intimate partner violence. *Health Education & Behavior, 42*(4), 433-435.

199. Zakocs, R., & Freire, K. E. (2015). The DELTA PREP initiative accelerating coalition capacity for intimate partner violence prevention. *Health Education & Behavior, 42*(4), 458-470.

200. California Department of Health Services. (2006). California Statewide Policy Recommendations for the Prevention of Violence Against Women.

201. Bagnato, N. (2016, May. 26). Informational Interview [Telephone interview].

202. Center for Disease Control and Prevention. (2014). CDC Grand Rounds: A Public Health Approach to Prevention of Intimate Partner Violence.

203. California Department of Health Services. (2006). California Statewide Policy Recommendations for the Prevention of Violence Against Women.

204. Santa Clara County. (2015). Santa Clara County Intimate Partner Violence Blue Ribbon Task Force Bylaws.

205. Reed, E., Silverman, J. G., Welles, S. L., Santana, M. C., Missmer, S. A., & Raj, A. (2009). Associations between perceptions and involvement in neighborhood violence and intimate partner violence perpetration among urban, African American men. *Journal of Community Health, 34*(4), 328-335.

206. Raghavan, C., Mennerich, A., Sexton, E., & James, S. E. (2006). Community violence and its direct, indirect, and mediating effects on intimate partner violence. *Violence Against Women, 12*(12), 1132-1149. doi:12/12/1132 [pii]

207. Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). Connecting the Dots: An overview of the links among multiple forms of violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Oakland, CA: Prevention Institute.

208. Tsao, B., Davis, R. (2015). *In Defense of Childhood: Maximizing outcomes through multisector engagement*. Oakland, CA: Prevention Institute.

209. Anderson-Moore, K., Stratford, B., & Caal, S. (2015). *Preventing violence: Understanding and addressing determinants of youth violence in the United States*. Bethesda,MD: Child Trends.

210. Lyles, A., Davis, R., Cohen, L., Lester, L. (2015). *A Good Solution Solves Multiple Problems: Exploring prevention strategies that address multiple forms of violence*. Prevention Institute, Oakland, CA

211. Commission on Social Determinants of Health (CSDH), World Health Organization (WHO). (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Final report of the CSDH. Geneva: World Health Organization.

212. Pañares R, Mikkelsen L, Do R. (2016). *The Community-Centered Health Home Model: Updates and Learnings*. Oakland, CA: Prevention Institute.

213. National Center for Injury Prevention and Control, Division of Violence Prevention. (2016). Intimate Partner Violence: Definitions. Atlanta, GA. Center for Disease Control and Prevention.

214. Braveman, P. A., Kumanyika, S., Fielding, J., Laveist, T., Borrell, L., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: The issue is justice. *American Journal of Public Health, 101*, 149-155.

215. World Health Organization. (2008). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Geneva, SUI: WHO.

216. Davis R. (2014). *Measuring what works to achieve health equity: Metrics for the Determinants of Health*. Oakland, CA: Prevention Institute.

217. Office of Disease Prevention and Health Promotion. *Healthy People 2020*.

218. Burtle, A. What is structural violence? [Blog post].