
Review Article

Communities are not all created equal: Strategies to prevent violence affecting youth in the United States

Larry Cohen, Rachel Davis, and Anna Realini*

US: Prevention Institute, 221 Oak Street, Oakland, CA 94607, USA

*Corresponding author. E-mail: anna@Preventioninstitute.org

Abstract We describe violence in the United States (US) and solutions the Urban Networks to Increase Thriving Youth (UNITY) Initiative has developed, led by Prevention Institute, a US non-governmental organization (NGO) and authors of this article, with initial funding from the US Centers for Disease Control and Prevention (CDC). Safety distribution across populations is unequal, while public health research has identified aspects of community environments that affect the likelihood of violence, or risk and resilience factors. An overwhelming number of risk factors have accumulated in some US communities, disproportionately impacting young people of color. US policies, systems, and institutions powerfully shape how and where these factors manifest. Violence is preventable, not inevitable. We argue that comprehensive strategies for improving community environments can reduce violence and promote health equity. We present lessons, tools, and frameworks that UNITY cities use to adapt for international application, including multi-sector collaboration, strategies for influencing policy and legislation, and strengthening local violence prevention efforts.

Journal of Public Health Policy (2016) 37, S81–S94.

doi:10.1057/s41271-016-0005-4

Keywords: violence prevention; youth violence; health equity; social determinants of health; Spectrum of Prevention; risk and resilience

Introduction

This paper describes the grave problem of violence in the United States (US) and the strategies developed by the UNITY initiative, (Urban Networks to Increase Thriving Youth Through Violence Prevention), a collaborative of large US cities committed to reducing violence. UNITY is facilitated by Prevention Institute, a US NGO initially funded by the US Centers for Disease Control and Prevention. Violence, as defined by



the World Health Organization, is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that results in injury, death, psychological harm, or deprivation.¹ Injuries and violence are the leading causes of death among children, adolescents, and young adults in the US and disproportionately affect young people of color.²

Fortunately, there is a strong and growing evidence base that confirms that violence is preventable. Preventing violence has tremendous value, through saving lives, saving money, fostering well-being, promoting health equity, and strengthening communities.³ Since 2005, UNITY has built support for effective, sustainable efforts to prevent violence before it occurs, so that urban youth can thrive in safe environments with ample opportunities and supportive relationships. The UNITY City Network openly shares concerns and strategies with one another and Prevention Institute synthesizes learnings, creates tools, and helps cities develop, implement, and evaluate strategies. The group collectively advanced the notion that violence prevention was a critical national concern and that cities needed a coordinated, public health approach to preventing violence.

In 2006, UNITY conducted the Assessment of Youth Violence Prevention Activities in USA. Cities. Researchers conducted interviews with mayors, police chiefs, school superintendents, and public health directors in one third of the largest US cities. The assessment revealed that violence was a major concern; law enforcement and criminal justice were the most prevalent strategies used to address it; responses were not perceived to be highly effective or adequate; most cities lacked a comprehensive strategy; few cities reported using primary prevention to stop violence before it occurs; and informants lacked a shared knowledge of existing youth violence prevention resources available in their cities. Importantly and perhaps surprisingly, the cities with the greatest *coordinated approach* also had the lowest rates of youth violence.⁴

In response to these findings, UNITY developed The *UNITY RoadMap: A Framework for Effectiveness and Sustainability*.⁵ UNITY staff developed it in partnership with city representatives and advisors from across the US as a framework for understanding the key elements needed to prevent violence before it occurs and to sustain these efforts in cities. The *UNITY RoadMap*



1. helps cities understand what is needed locally as well as the current status of their efforts (starting point);
2. describes the core elements necessary to prevent violence before it occurs (milestones); and
3. provides information, resources, and examples to support cities in planning, implementation, and evaluation.

The *UNITY RoadMap* is most effective when tailored to the needs of a particular city and could be useful for cities in other countries. Cities worldwide can modify it to address local circumstances.

The Role of Community Risk and Resilience Factors

A broad focus on reducing risk and increasing resilience among people and communities can play an important role in reducing violence.⁶ UNITY advances comprehensive and multidisciplinary efforts for addressing the underlying contributors to violence (risk factors) and for building resilience. This is sometimes called a public health approach to preventing violence. ‘Risk factors’ are detrimental community, family, or individual circumstances that increase the likelihood that violence will occur.⁷ ‘Resilience factors’ support the healthy development of individuals, families, schools, and communities, and build capacity for positive relationships and interactions, thereby reducing the long-term impact from exposure to violence (see Table 1). All people and communities deserve equal opportunities to be healthy and safe, but opportunities are not distributed evenly across our society. Multiple risk and resilience factors interact to make violence more or less likely in a community or in society.⁸

The Impact of Inequity

Some communities, particularly communities of color and low-income communities, accumulate an overwhelming number of risk factors for violence and at the same time lack adequate compensatory resilience factors to protect against violence.⁹ Worldwide, as the gap widens between those with more opportunities and those with fewer, the level of violence in a society increases.¹⁰ Entire communities, particularly

**Table 1:** Key community-level risk and resilience factors

<i>Community-level risk factors</i>	<i>Community-level resilience factors</i>
<ul style="list-style-type: none">• Residential segregation• Poverty• Community deterioration• Alcohol and other drugs• Lack of academic opportunity• Incarceration and re-entry• Biased media coverage• Weapons• Belief in inevitability of violence	<ul style="list-style-type: none">• Economic opportunity• Built environment/community design (decisions re: land use, housing, and transportation)• Strong social networks and trust• Positive ethnic, racial, and intergroup relations• Quality schools• Opportunities for meaningful participation

Source: Ref. ⁵¹.

low-income communities and communities of color, experience traumatizing events and conditions.¹¹ Young people in urban neighborhoods often experience persistent or chronic traumatic stress and fear of violence. In the US, homicide is the leading cause of death for African Americans and Asians and Pacific Islanders between the ages of 10 and 24, (grouped as they are in US health statistics) and the second-leading cause of death for Latinos of the same age.¹² African American young men, 15- to 19-year old, are six times more likely to be homicide victims as their white peers¹³ and African American children, age 2–17, are 20 times more likely to witness a murder than white children.^{14, 15}

The difference in accumulation of community risk or resilience factors is one example of health inequities, the unnecessary, avoidable, and unfair differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups. They result from historical and present-day policies, practices, and procedures on the part of government and other institutions.¹⁶ For example, inequities in housing, education, health-care, criminal justice, land use, community design, and workforce and economic development have led to significant differences in community and individual opportunity and resources.¹⁷ Whether these actions are deliberate and intentional, inadvertent, or neglectful, individually and cumulatively they have contributed to unjust disparities in health and safety.^{18–20}



Violence also worsens other health outcomes, further exacerbating inequities.^{21–23} The presence of and fear of violence causes individuals to be less physically active and influences where people live, work, and shop; whether parents let their children play outside and walk to school; and whether or not a grocery store or workplace will locate in a community, influencing whether people have access to healthy food and livable wages.²⁴ Adverse Childhood Experience (ACE) studies are US studies that assess the extent to which a child is exposed to adverse experiences and evaluates that child's health and social outcomes more than a generation later. These studies have found that adverse childhood experiences accumulate and people who experienced trauma when they were young—including experiences of neglect or of having witnessed or experienced violence—were at significant risk of experiencing further violence.^{25, 26} Strikingly, the studies also found that exposure to violence and other trauma is so destructive as it increases the likelihood of developing virtually every other health problem, from anticipated ones like depression, drug use, alcoholism, and other mental health challenges, to illnesses such as asthma, heart disease, and diabetes.^{27–29} Exposure to trauma also leads to increased risky behavior for children, including early initiation of smoking, sexual activity, and pregnancy; antisocial attitudes; lack of involvement in activities and school, and poor academic performance.³⁰

Intentionally advancing violence prevention and health equity is needed to provide all people with fair opportunities to have the best possible health and safety.³¹ Resilience factors can be protective against violence even when risk factors are present; like risk, the effects of resilience factors accumulate.^{32–34} The presence of quality schools, health and mental health facilities, libraries, recreational centers and parks buffer against the likelihood of violence and chronic trauma. Children in communities with more of these assets are less likely to engage in violence and other high-risk behaviors and are more likely to have positive attitudes and behaviors such as good health, healthy eating, success in school, healthy relationships, and self-control.²² The specific institutions and sectors that have played roles in producing health inequities now have invaluable roles to play in producing equitable health and safety outcomes.

Frameworks for Changing Community Environments to Prevent Violence

The UNITY City Network has used several related frameworks to develop strategies for addressing the impact of community environment on health and safety.³⁵⁻³⁷ These frameworks build on the World Health Organization's (WHO) Commission on Social Determinants of Health³⁸ overarching recommendations for addressing environmental impact:

1. Improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age. This includes safe housing and transportation, and other physical aspects of a neighborhood; fair employment opportunities and decent working conditions; and quality early childhood and schooling.
2. Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—at the global, national, and local levels.³⁹

Two Steps to Prevention (see Figure 1) is a framework developed by Prevention Institute for helping to analyze the underlying causes of illness, injury, and health inequities and for identifying key opportunities for prevention. It helps communities, practitioners, and policy-makers to develop community strategies to systematically address violence and inequity.⁴⁰ The framework shows how the environment sets the stage for behaviors and exposures, which then result in illnesses and injuries.

To get to the actual causes of illness and injury, we must step back from a specific disease or injury (e.g., a gunshot wound or heart disease)

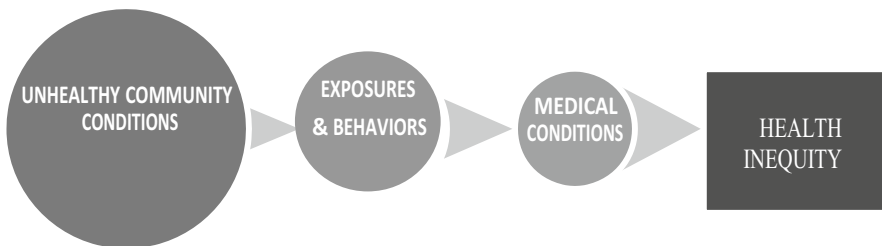


Figure 1: Two steps to prevention framework. Source: Ref. ⁵⁴. Adapted from Ref. ⁵⁵



Table 2: Community factors associated with health and safety

People
Social networks & trust
Participation & willingness to act for the common good
Norms and culture
Place
What's sold & how it's promoted
Look, feel & safety
Parks & open space
Getting around
Housing
Air, water & soil
Arts & culture
Equitable opportunity
Living wages & local wealth
Education

Source: Ref. ⁵². Adapted from Ref. ⁵³.

to the behavior or exposure (e.g., violence or eating unhealthy food) and then to the underlying community conditions that make such behavior and exposures more likely (e.g., high density of alcohol outlets in low-income communities and lack of access to healthy food). Researchers have identified specific behaviors and exposures and related community conditions (such as poverty, racism, and other forms of oppression) that are strongly linked to injuries, chronic diseases, and major causes of death.⁴¹ Prevention Institute has identified 12 specific aspects of the community environment (see Table 2) associated with health, safety, and health equity, called the *community determinants of health*.

Comprehensive Approaches for Preventing Violence

As UNITY has found, educational efforts and individual programs are not sufficient for addressing the community factors that lead to childhood and youth exposure to violence. The ‘Spectrum of Prevention’^{42, 43} is a tool created by Prevention Institute for developing comprehensive strategies to change environments, systems, and norms. The Spectrum can be applied to virtually any preventable concern and Table 3 provides examples of violence prevention strategy.

**Table 3:** Spectrum of Prevention and its application to violence prevention⁴⁴

<i>Level</i>	<i>Description</i>	<i>Examples</i>
1. Influencing policy and legislation (<i>see principles for policies that prevent violence below</i>)	Developing strategies to change laws and policies to influence outcomes	Develop public policies restricting alcohol density and gun availability. Engage the planning commission to change zoning laws, enforce conditional use permits, and allocate redevelopment funding in ways that discourage new liquor or gun businesses
2. Changing organizational practices	Adopting regulations and shaping norms to improve health and safety	Reduce truancy and drop-out rates by ensuring that school discipline practices are uniform across student populations so students of color are not punished more severely than white students for the same infractions. Increase after-school and recreation opportunities. Prioritize economic development and job training for youth
3. Fostering coalitions and networks	Bringing together groups and individuals to achieve broader goals and have greater impact	Develop city-wide violence prevention plans and coalitions including city planners, local businesses, education, librarians, and other non-traditional partners. When practitioners understand solutions to violence and how their activities align with those of other sectors, they can work in ways that also reduce community violence
4. Educating providers	Informing influential community members and other providers who will transmit skills and knowledge to others	Train journalists to include a public health and prevention perspective when they report on crime and violence and help reporters cover the topic comprehensively, rather than primarily highlighting individual acts, particularly those by people of color

**Table 3:** *continued*

<i>Level</i>	<i>Description</i>	<i>Examples</i>
5. Community education	Reaching groups of people with information and resources to promote health and safety	Increase the number of positive role models and mentors who can share positive messages with youth networks. Consider recruiting adults who are already involved in youth employment and job training programs for this role
6. Individual knowledge and skills	Enhancing an individual's capacity to prevent injury and illness, and promote wellness and safety	Implement universal school-based violence prevention programs that create a safe climate for all children to learn

Source: Adapted from Ref. ⁴⁴, p. 22.

Violence is Preventable

Violence is a significant health and equity issue that affects communities in every country. Although different countries and cities may face dramatically different circumstances, each community faces similar underlying conditions, such as poverty, inequities, community trauma, proliferation of guns, and the presence of alcohol and drugs, as well as the policies and practices that lead to these factors.

Yet we know that violence is preventable and the UNITY collaborative is one of a growing number of initiatives that work to decrease the likelihood of violence occurring in the first place. An eight-year UNITY evaluation demonstrated that engaged cities have enhanced city-wide strategic planning to address violence.⁴⁵ The cities rely more on comprehensive prevention strategies across sectors and with communities to address violence before it occurs, moving beyond traditional approaches of intervention, suppression, or enforcement.⁴⁶ Cities that have developed or are developing strategic plans include Baltimore, Kansas City, New Orleans, Seattle, and Oakland to name a few.

Minneapolis is one UNITY city that has successfully implemented a coordinated, multi-sector, city-wide strategic plan for addressing youth violence. The plan had four goals:

- to connect every young person to a trusted adult,



- to intervene at the first sign of at-risk behavior,
- to restore youth who have gone down the wrong path, and
- to facilitate everyone to unlearn the culture of violence.

As the Mayor said, “The public health approach means backing up from the emergency room (ER) where you bandage the wound and starting at the beginning, understanding why that person is there in the ER at all.”⁴⁷ Within 3 years of developing a strategic plan in 2006, homicides of youth decreased by 77 %, and the number of people under 18-year old either suspected of or arrested for violent crime dropped to the lowest in a decade.^{48, 49} The state legislature also passed the Youth Violence Prevention Act, which mandated the Minnesota Department of Health to replicate Minneapolis’ success in four other cities.⁵⁰

The approaches and tools used by UNITY can be tailored and adapted for any city or locality across the world to achieve broad and sustainable impact, including improving equity, shifting norms, collaborating with non-traditional partners to develop comprehensive strategic plans for addressing multiple forms of violence, and increasing the effectiveness of prevention efforts to address the underlying factors and systems that perpetuate violence and injury *in the first place*. Young people in particular need environments that foster connection, identity, opportunity, and hope, particularly in the most disadvantaged communities. Community members, municipalities, policymakers, and practitioners can work together now to support safe, equitable communities.

About the Authors

Larry Cohen MSW, is the Founder and Executive Director of Prevention Institute and Chair of UNITY (Urban Networks to Increase Thriving Youth). Email: larry@preventioninstitute.org.

Rachel Davis MSW, is Managing Director at Prevention Institute and Chair of UNITY (Urban Networks to Increase Thriving Youth). Email: Rachel@preventioninstitute.org.

Anna Realini is the Manager of the Executive Office at Prevention Institute. Email: anna@Preventioninstitute.org.



References

1. Global Status Report on Violence Prevention. (2014) World Health Organization. http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/, accessed 30 April 2016.
2. Prevention Institute. (2011) UNITY fact sheet: Links between violence and health equity. Oakland: Prevention Institute, <http://www.preventioninstitute.org/component/jlibrary/article/id-311/127.html>, accessed 5 May 2016.
3. Davis, R.A. (2011) The value of prevention. In: D.M. Patel and R.M. Taylor (eds.) *Social and Economic Costs of Violence: The Value of Prevention Workshop Summary*. Washington, D.C.: National Academies Press, pp. 112–118. <http://www.nap.edu/catalog/13254/social-and-economic-costs-of-violence-workshop-summary>, accessed 5 May 2016.
4. Weiss, B. (2008) *An Assessment of Youth Violence Prevention Activities in USA. Cities*. Los Angeles: Southern California Injury Prevention Research Center, UCLA School of Public Health. <http://www.ph.ucla.edu/sciprc/pdf/UNITY-SCIPRCassessment.June2008.pdf>, accessed 24 April 2016.
5. Prevention Institute. (2008) UNITY roadmap: A framework for effectiveness and sustainability. http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=308&Itemid=127, accessed 5 May 2016.
6. Davis, R.A., Cook, D. and Cohen, L. (2005) A community resilience approach to reducing ethnic and racial disparities in health. *American Journal Public Health* 95(12): 2168–2173. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449502/>, accessed 5 May 2016.
7. Dahlberg, L.L. and Krug, E.G. (2002) Violence—A global public health problem, World Health Organization, Geneva. http://www.who.int/violence_injury_prevention/world_report/en/chap1.pdf. (The first chapter of the World Report on Violence and Health (2002), World Health Organization: Geneva. http://www.who.int/violence_injury_prevention/violence/world_report/chapters/en/).
8. Garbarino, J. (2011) Violent children: where do we point the finger of blame? *Archives of Pediatrics and Adolescent Medicine* 155(1): 13–14. <http://archpedi.jamanetwork.com/article.aspx?articleid=190189>, accessed 5 May 2016.
9. Davis, R. A., Cook, D., & Cohen, L. (2005). A community resilience approach to reducing ethnic and racial disparities in health. *American Journal of Public Health*, 95(12), 2168–2173.
10. Wilkinson, R. and Pickett, K. (2009) *The Spirit Level: Why Greater Equality Makes Societies Stronger*. New York: Bloomsbury Press. <https://www.equalitytrust.org.uk/resources/the-spirit-level>, accessed 5 May 2016.
11. Pinderhughes, H., Davis, R. and Williams, M. (2016) *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma*. Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-372/127.html>, accessed 5 May 2016.
12. Youth Violence National and State Statistics at a Glance Center for Disease Control and Prevention. (2012) Centers for Disease Control and Prevention. <http://www.cdc.gov/ViolencePrevention/pdf/yv-datasheet-a.pdf>, accessed 5 May 2016.
13. Children's Defense Fund. (2007) *America's cradle to prison pipeline*. Washington, D.C.: Children's Defense Fund. <http://www.childrensdefense.org/library/data/cradle-prison-pipeline-report-2007-full-lowres.pdf>, accessed 5 May 2016.
14. Children's Defense Fund. (2011) *Portrait of Inequality 2011: Black Children in America*. Washington, D.C.: Children's Defense Fund. <http://www.childrensdefense.org/campaigns/black-community-crusade-for-children-III/bccc-assets/portrait-of-inequality.pdf>, accessed 5 May 2016.
15. Finkelhor, D., Ormrod, R., Turner, H. and Hamby, S.L. (2005) The victimization of children and youth: a comprehensive, national survey. *Child Maltreatment* 10(1): 5–25. <http://www.unh.edu/ccrc/pdf/CV73.pdf>, accessed 5 May 2016.



16. Braveman, P. Kumanyika, S. Fielding, J. and LaVeist, T. (2011) Health disparities and health equity: The issue is justice. *American Journal of Public Health* 101(Suppl 1): S149–S155. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222512/>, accessed 30 April 2016.
17. Braveman, P., Egerter, S. and Williams, D. (2011) Race, socioeconomic factors and health. Robert Wood Johnson Foundation. <http://www.rwjf.org/en/library/research/2011/04/race-and-socioeconomic-factors-affect-opportunities-for-better-h.html>, accessed 5 May 2016.
18. Cohen, L., Iton, A., Davis, R.A. and Rodriguez, S.A. (2009) *Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety*. Oakland: Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-81/127.html>, accessed 5 May 2016.
19. Smedley, B., Jeffries, M., Adelman, L. and Cheng, J. (2008) *Race, Racial Inequality and Health Inequities: Separating Myth from Fact*. San Francisco, CA: Unnatural Causes. http://www.unnaturalcauses.org/assets/uploads/file/Race_Racial_Inequality_Health.pdf, accessed 5 May 2016.
20. Whitehead, M. (1992) The concepts and principles of equity and health. *International Journal of Health Services* 22(3): 429–445. http://salud.ciee.flacso.org.ar/flacso/optativas/equity_and_health.pdf, accessed 5 May 2016.
21. Prevention Institute. (2011) *UNITY Fact Sheet: Links Between Violence and Health Equity*. Oakland: Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-311/127.html>, accessed 5 May 2016.
22. Prevention Institute. (2011) *UNITY Fact Sheet: Links Between Violence and Mental Health*. Oakland: Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-301/127.html>, accessed 5 May 2016.
23. Prevention Institute. (2011) *UNITY Fact Sheet: Links Between Violence and Chronic Illness*. Oakland: Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-301/127.html>, accessed 5 May 2016.
24. Cohen, L., Davis, R.A., Lee, V. and Valdovinos, E. (2010) *Addressing the Intersection: Preventing Violence and Promoting Healthy Eating and Active Living*. Oakland: Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-267/127.html>, accessed 5 May 2016.
25. Anda, R.F. Chapman, D.F., Dong, M., Dube, S.R., Edwards and Felitti, V.J. (2005) The wide-ranging health consequences of adverse childhood experiences. *Victimization of Children and Youth: Patterns of Abuse, Response Strategies*. New Jersey: Civic Research Institute. <https://acestoohigh.com/research/>, accessed 5 May 2016.
26. Dube, S.R., Anda, R.F., Felitti, V.J., Edwards, V.J. and Williamson, D.F. (2002) Exposure to abuse, neglect and household dysfunction among adults who witnessed intimate partner violence as children. *Violence and Victims* 17: 3–17. <http://www.ncbi.nlm.nih.gov/pubmed/11991154?dopt=Abstract>, accessed 5 May 2016.
27. Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V. et al. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Prevention Medicine* 14(4): 245–258. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/9635069>, accessed 5 May 2016.
28. Carver, A., Timperio, A. and Crawford, D. (2008) Perceptions of neighborhood safety and physical activity among youth: The CLAN study. *Journal of Physical Activity and Health* 5(3): 430–444. <http://link.springer.com/article/10.1007/s11524-008-9284-9>, accessed 5 May 2016.
29. Kilpatrick, D.G., Ruggiero, K.J., Acierno, R., Saunders, B.E., Resnick, H.S. and Best, C.L. (2003) Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology* 71(4): 692–700. <http://psycnet.apa.org/journals/ccp/71/4/692/>, accessed 5 May 2016.
30. Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V. et al. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal*



- of *Prevention Medicine*, 14(4): 245–258. <http://www.ncbi.nlm.nih.gov/pubmed/9635069>, accessed 5 May 2016.
31. Braveman, P. (2006) Health disparities and health equity: concepts and measurement. *Annual Reviews of Public Health* 27: 167–194. <http://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.27.021405.102103>, accessed 5 May 2016.
 32. Prothrow-Stith, D. and Davis, R. (2010) A public health approach to preventing violence. In: L. Cohen, V. Chavez, S. Chehimi (eds.) *Prevention Is Primary: Strategies for Community Well Being*. <http://www.preventioninstitute.org/press/highlights/491-just-released-prevention-is-primary-second-edition.html>.
 33. Smith, C., Lizotte, A.J., Thornberry, T.P. and Krohn, M.D. (1995). Resilient youth: Identifying factors that prevent high-risk youth from engaging in delinquency and drug use. In: J. Hagen (ed.) *Delinquency and Disrepute in the Life Course: Contextual and Dynamic Analysis*. JAI Press, pp. 217–274.
 34. Bradley, R. H., Mundfrom, D. J., Casey, P., Kellher, K., & Pope, S. (1994). Early indications of resilience and their relation to experiences in the home environment of low birthweight, premature children living in poverty. *Child Development*, 65, 346–360.
 35. Dahlberg, L.L. and Krug, E.G. (2002) Violence—A Global Public Health Problem, World Health Organization, Geneva. http://www.who.int/violence_injury_prevention/violence/world_report/en/chap1.pdf. (The first chapter of the World Report on Violence and Health (2002), World Health Organization: Geneva. http://www.who.int/violence_injury_prevention/violence/world_report/chapters/en/).
 36. Centers for Disease Control and Prevention. (2004) *Sexual Violence Prevention: Beginning the Dialogue*. Atlanta: Center for Disease Control and Prevention. <http://www.cdc.gov/violenceprevention/pdf/svprevention-a.pdf>, accessed 5 May 2016.
 37. Cohen, L. Davis, R. and Graffunder, C. (2005) Before it occurs: Primary prevention of intimate partner violence and abuse. In: P.R. Salber and E. Taliaferro (eds.) *The Physician's Guide to Intimate Partner Violence and Abuse: A Reference for All Health Care Professionals*. Volcano: Volcano Press, pp. 89–100. <http://www.preventioninstitute.org/component/jlibrary/article/id-40/127.html>, accessed 5 May 2016.
 38. CSDH. (2008) Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization. http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf, accessed 5 May 2016.
 39. Solar, O. and Irwin, A. (2010) A conceptual framework for action on the social determinants of health. *Social Determinants of Health Discussion (Policy and Practice)*. Geneva: World Health Organization. http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf, accessed 5 May 2016.
 40. Davis, R.A., Cohen, L. and Rodriguez, S. (2010) Toward health equity: A prevention framework for reducing health and safety disparities. In: B.J. Healey and R.S. Zimmerman, Jr. (eds.) *The New World of Health Promotion: New Program Development, Implementation, and Evaluation*, 1st ed. Sudbury: Jones and Bartlett Publishers, pp. 163–194. <http://www.preventioninstitute.org/component/jlibrary/article/id-199/127.html>, accessed 5 May 2016.
 41. McGinnis, J.M. and Foege, W.H. (1993) Actual causes of death in the United States. *Journal of the American Medical Association* 270(11): 2207–2212. <http://www.ncbi.nlm.nih.gov/pubmed/8411605>, accessed 5 May 2016.
 42. Cohen, L. and Swift S. (1999) The spectrum of prevention: Developing a comprehensive approach to injury prevention. *Injury Prevention* 5(3): 203–207. PMID: PMC1730534. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1730534/>, accessed 24 May 2016.
 43. Prevention Institute. (2006) Sexual violence and the spectrum of prevention: Towards a community solution. <http://www.preventioninstitute.org/component/jlibrary/article/id-97/127.html>, accessed 5 May 2016.



44. Cohen, L. and Erlenborn, J. (2001) Cultivating peace in Salinas: A framework for violence prevention. http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=51&Itemid=127, accessed 5 May 2016.
45. Prevention Institute. (2013) *Shifting the Paradigm: UNITY's Impact on the Practice of Prevention*. Oakland: Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-348/127.html>, accessed 5 May 2016.
46. Prevention Institute. (2013) *Shifting the Paradigm: UNITY's Impact on the Practice of Prevention*. Oakland: Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-348/127.html>, accessed 5 May 2016.
47. Rybak, R.T., UNITY. (2012) City voices and perspectives. <http://www.preventioninstitute.org/component/jlibrary/article/id-324/127.html>, accessed 5 May 2016.
48. City of Minneapolis. (2011) *US Attorney General Holder Lauds Minneapolis' Youth Violence Prevention Initiative*. http://www.minneapolismn.gov/news/news_20110527youthviolenceprevention_holder, accessed 5 May 2016.
49. UNITY, Prevention Institute. (2011) State of the Blueprint Report. Blueprint for Action Youth Violence Prevention Conference, Minneapolis, MN. <http://www.preventioninstitute.org/component/jlibrary/article/id-314/127.html>, accessed 5 May 2016.
50. Prevention Institute. (2011) *City voices and Perspectives: Blueprint for Action—Preventing Violence in Minneapolis*. Oakland: Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-314/127.html>, accessed 5 May 2016.
51. Prevention Institute. (2009). *Preventing Violence: A Primer*. <http://www.preventioninstitute.org/component/jlibrary/article/id-144/127.html>.
52. Prevention Institute. (2013) *THRIVE (Community Tool for Health & Resilience In Vulnerable Environments)*. Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-96/127.html>.
53. Prevention Institute. (2007) Good Health Counts: A 21st Century Approach to Health and Community for California. The California Endowment. (For full list of elements and explanation see: Box 1: Key Community Factors, p. 10.) <http://www.preventioninstitute.org/component/jlibrary/article/id-85/127.html>.
54. Prevention Institute. (2015) Measuring what works to achieve health equity: Metrics for the determinants of health. <http://www.preventioninstitute.org/component/jlibrary/article/id-367/127.html>.
55. Cohen, L., Iton, A., Davis, R. and Rodriguez, S. (2009) *A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety*. Commissioned by The Institute of Medicine. Prevention Institute. <http://www.preventioninstitute.org/component/jlibrary/article/id-81/127.html>.

Editors' Note

This article is one of ten papers in a Special Sponsored Issue of the Journal of Public Health Policy in 2016, [Violence and Health: Merging Evidence and Implementation](#).