**Safe Futures Maryland**
**Center for Prevention of Intimate Partner Violence**
**The Family Crisis Center of Baltimore County, Inc.**

FAMILY CRISIS CENTER
OF BALTIMORE COUNTY

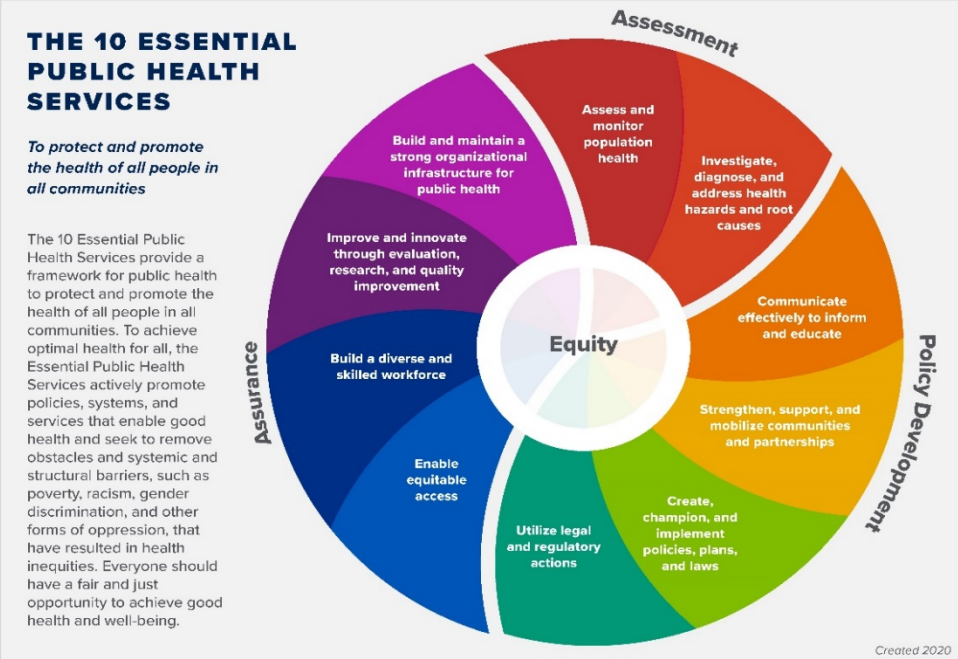
## Overview: Introduction to a Public Health Approach

What is a public health approach to domestic violence? How can a public health approach reduce domestic violence?

A public health approach to a problem involves taking a "***population***" approach. The focus of public health is to improve the safety, health, and well-being of entire populations. A population approach to violence requires *multi-systems, multi-agency, cross-disciplinary approaches*, based on an understanding that complex problems such as interpersonal violence require complex solutions. This approach emphasizes *collective action* to have a greater impact on the problem.

A public health approach to a problem also emphasizes ***prevention.*** Prevention is based on a belief that violence can be prevented and its adverse impacts can be diminished. When people hear the term "prevention" they often think of providing education or an intervention to prevent a problem from occurring in the first place. However, the public health framework includes a continuum, in which prevention occurs at several levels. This means that prevention is considered to be an intervention, and many interventions have a preventive impact. These levels of prevention will be explored in depth in this document.

A public health approach to violence, including domestic violence, is based on belief that is itself based on evidence. Public health is a ***science-based discipline***. This approach centers on 10 core functions of public health, identified by the Center for Disease Control: [CDC - 10 Essential Public Health Services - CSTLTS]



A public health approach to a problem such as violence is based on data collection to formulate an assessment of the problem of violence, identify factors that influence violence such as risk and protective factors, identify causes and correlates, and pinpoint those factors that are amenable to intervention. This knowledge is then used to design, implement, monitor, and evaluate interventions to determine which interventions are effective. Another core function of public health is to then disseminate this information about effective, promising, and emerging practices and communicate effectively to people and communities about factors that influence violence and how to improve conditions to decrease violence. This effort involves strengthening and mobilizing communities and partnerships to improve conditions that reduce violence. Additional core functions center on bringing about systemic change to create and champion policies, plans, laws, and regulatory actions that can positively impact violence. Assuring equitable access to services, building a skilled workforce, assuring quality through ongoing monitoring, evaluation, and improvement, and supporting research-based innovation are also essential core functions of public health approaches.

The following is a guide for agencies working in the domestic violence/intimate partner violence (DV/IPV) sector. This guide introduces a public health framework and illustrates a model for service delivery at the individual, family, community, social, and systemic levels – known as an ***ecosystem*** approach. The guide includes training curricula to provide "roadmaps" to DV/IPV agencies and staff in bringing a public health lens to the work, in order to have a greater impact in reducing and preventing interpersonal violence. The training objectives are:

- To provide information and guidance to DV/IPV agencies in bringing a public health approach to the prevention of interpersonal violence.
- To assist participants in understanding a public health approach to violence prevention and learning strategies at the system and agency level for advocating for and integrating preventive interventions and policies.

The guide includes information, training curricula for both program development and direct service delivery, white papers to support position statements and policy, and resources.

This guide emphasizes the importance of widening the lens on service delivery to include prevention and understanding why reacting to violence cannot be the starting point.

**Resources from the CDC on a public health approach to violence and DV/IPV: (*Text box or appendix)**

Intimate partner violence has long been recognized as a serious, highly prevalent, and preventable public health problem that affects millions of Americans across the life span. The national public health service, the Center for Disease Control (CDC), established the Division of Violence Prevention in 1993, under the newly created National Center for Injury Prevention and Control. In 1996, the World Health Assembly recognized violence as a leading worldwide public health problem and in 2000 the World Health Organization (WHO) created the Department of Injuries and Violence Prevention. In 2002, the CDC established a program (DELTA) to focus on primary prevention of intimate partner violence. From 2009 to the present, the CDC has produced:

- Violence Prevention Home Page (cdc.gov)
- The Veto Violence website (est. 2009), with violence prevention tools, trainings, and resources based on the best available evidence and research. The focus is on prevention of child abuse, intimate partner violence, sexual violence, youth violence and suicide, as well as addressing social norms
  https://vetoviolence.cdc.gov/apps/main/home
- A comprehensive teen dating violence prevention initiative for 11-14-year-olds living in high risk urban communities, *Dating Matters,* launched in 2009
  https://www.cdc.gov/violenceprevention/intimatepartnerviolence/datingmatters/index.html
- A surveillance system on intimate partner violence, sexual violence, and stalking, The National Intimate Partner and Sexual Violence Survey (NISVS), implemented in 2010 in collaboration with the Dept. of Defense and the National Institute of Justice
  https://www.cdc.gov/violenceprevention/datasources/nisvs/index.html
- *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence,* released in 2014, and *Strategic Vision for Connecting the Dots in 2016,* offering a cross-cutting approach
  *https://www.cdc.gov/violenceprevention/publichealthissue/strategicvision.html*
- A suite of technical packages, released in 2016 and 2017, to offer states and communities the best available evidence in programs, policies, and practices to prevent child maltreatment, sexual violence, youth violence, suicide, and intimate partner violence
  https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf
- Ongoing reports, including DELTA Impact Theory of Change
  https://www.cdc.gov/violenceprevention/intimatepartnerviolence/delta/impact/index.html
  https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html
- Futures Without Violence is a national organization working for over 30 years on ending violence against women and children. Foci include preventing teen dating violence and building healthy relationship skills, coaching boys into men, preventing sexual assault on campus, global violence prevention, and engaging health providers, educators, and the workplace.
  https://www.futureswithoutviolence.org
- Preventing Violence: A Review of Research, Evaluation, Gaps, and Opportunities
  Preventing Violence:

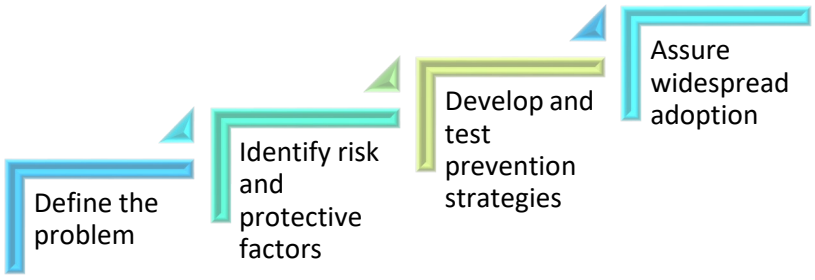
## SECTION 1: A Public Health Approach to Domestic Violence/Intimate Partner Violence

The focus of public health is to improve the safety, health, and well-being of entire populations. Public health approaches use a systematic, scientific, multi-disciplinary approach to identify and control the incidence and prevalence of a public health problem, to prevent new cases from occurring, and to mitigate the impacts and consequences of occurrences. Public health approaches include prevention, health promotion, and monitoring. Public health has a role in building capacity within communities to implement evidence-based practices, programs, and policies and to facilitate the scale-up of effective prevention strategies. This is a broad and encompassing approach to tackling a complex issue such as violence.

Much of the service delivery system in the DV/IPV sector is one of response, particularly to crises involving high risk, high severity situations. While this important work must continue, it is equally important that DV/IPV agencies begin to expand the work "*upstream*," to lessen the "*downstream*" consequences. This refers to a popular analogy used in public health, involving villagers rushing to the river to rescue victims from drowning. As the villagers work to pull people out of the swift waters, some begin to ask why there are so many people drowning in the river. As a few rescuers shift their attention upstream to investigate, they find that a natural bridge has eroded and villagers attempting to cross the river are falling into the water and being carried downstream. To work *upstream* to repair the bridge or divert foot traffic becomes an obvious solution, by preventing individuals from ending up in the waters rushing *downstream.*

In order to work upstream, it is important for DV/IPV agencies to widen their lens to include a prevention viewpoint across services and systems. This includes engaging in opportunities to collaborate with partners in *multi-tier approaches* to violence intervention. This includes not only targeting those *at-risk* but also working to *reduce and prevent the risks of interpersonal violence* within the population . In DV/IPV, agencies have deferred to or depended upon the criminal justice system and the victim services system, which, arguably have become service and incarceration industries. Solutions involve integrating prevention into systemic level changes that address social and economic factors that contribute to violence in order to reduce the incidence and prevalence of interpersonal violence in our communities.

The public health approach to violence prevention includes **four steps** that seek to answer the questions "where does the problem begin?" and "how can we prevent it from occurring in the first place?" These steps are sequential and involve multiple people, organizations, and systems in the progression.




Step 1: Define the problem through systematic data collection. What is the problem? Collect data from a variety of sources on who, what, when, where, and how. Decide the scope and the burden of the problem. Provide ongoing surveillance and monitoring.

Step 2: Identify the risk and protective factors that impact violence. What are the causes and correlates? Why does violence occur and whom does it affect? Why does one person or community experience violence when another does not? What increases the risk and what decreases the likelihood of violence in the presence of risk?

Step 3: Design, implement, and evaluate interventions. Are there existing effective strategies, or what resources are needed to develop a new strategy based on what was learned in steps 1 and 2? What research partners can be located to test and evaluate what works, for whom? Did the strategy do what was intended? How is this information to be shared with others?

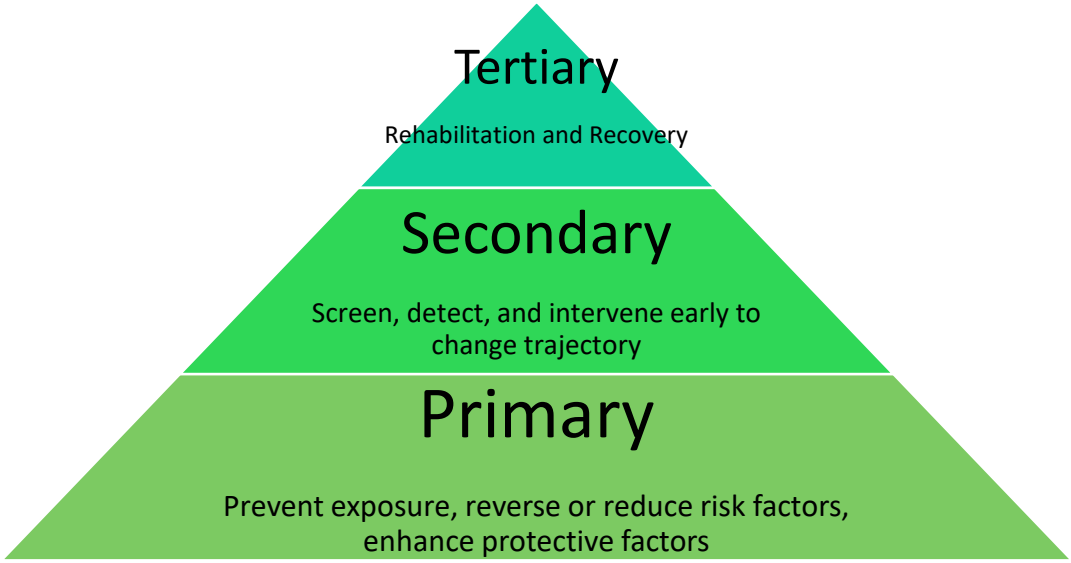
Step 4: Disseminate information about the strategies that have been shown to be effective. Who would benefit from this strategy? Locate and contribute to registries for evidence-based practices. Obtain training and technical assistance. Scale up effective programs and policies. Continue to evaluate outcomes, components, and cost-effectiveness to assure they produce the desired effect of preventing violence. What support and resources are available for ongoing implementation, monitoring, and evaluation?

**A Public Health Framework for Prevention: An Evolution Story**

A common model of prevention used for many years in public health is represented as pyramid, with primary prevention standing at the base of the pyramid, including efforts to prevent a problem before it occurs. *Primary prevention* efforts typically involve universal measures for the whole population, or targeted interventions to segments of the population known to be "at risk." Primary prevention aims to broaden the scope of intervention to impact more people and increase cost-effectiveness by preventing the need for more costly interventions. At the top of the pyramid is *a tertiary level of prevention*, providing services to individuals in which the problem has already occurred and progressed. Efforts at the top of the pyramid include more costly interventions directed toward a smaller number of people, designed to mitigate the acute and long-term impacts and negative consequences of the problem. In the middle of this pyramid sits *secondary prevention*, representing efforts to intervene early, when the problem has begun to appear, in order to stop, reverse, or delay the progression of the problem.

The greater the intensity of interventions required, the greater the cost of the services provided. These are located at the tip of the pyramid. The greatest potential for impact, with the broadest reach and lowest costs, is found at the base of the pyramid.

In violence intervention work, including the DV/IPV sector, the service delivery system operates as an "inverse pyramid," with the bulk of services directed at the fewest participants and with the highest costs. The middle of the pyramid represents early intervention opportunities and challenges, often neglected in the service delivery system in which services are directed to the high intensity, high-cost demands. Few would be willing to divert funds and services from those intended to prevent serious harm and even death.

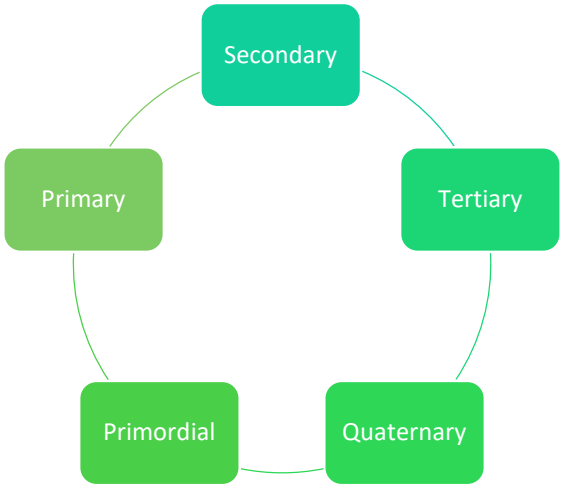


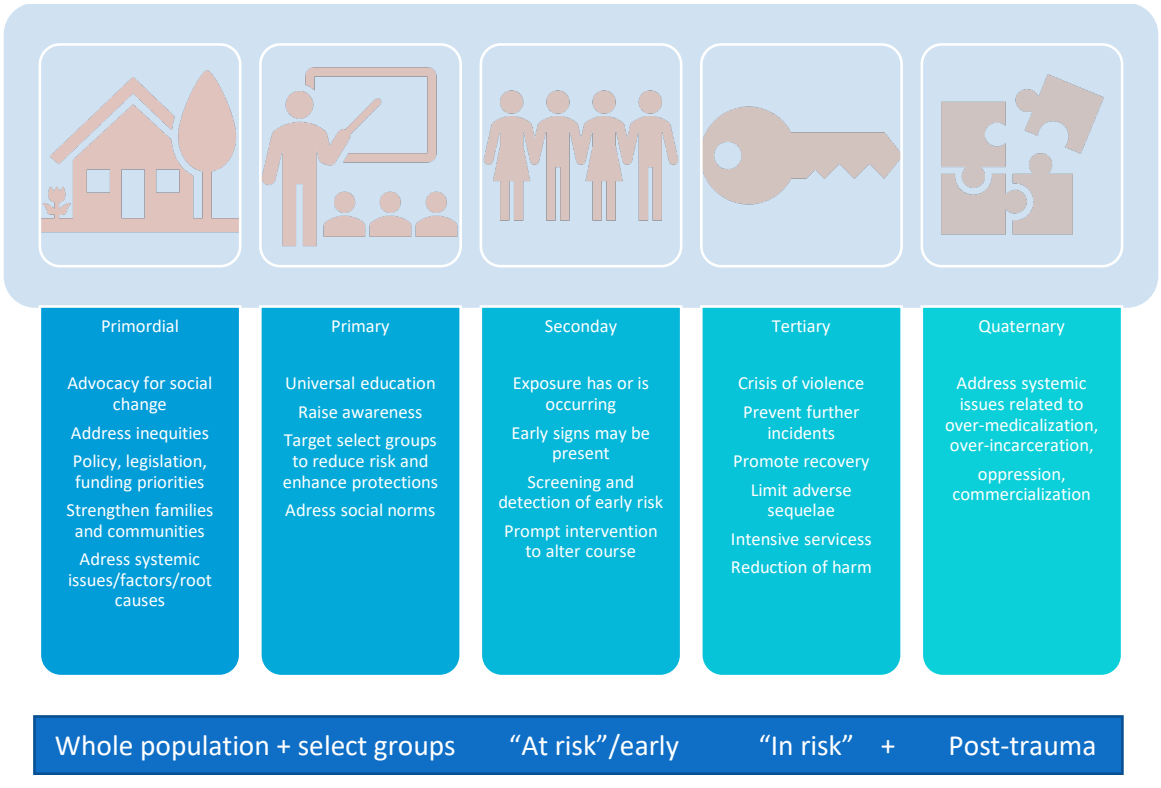

This prevention framework has proven to be more idealistic than realistic in the field of violence prevention. In responding to child maltreatment, intimate partner violence, and other forms of violence, the focus, interventions, and resources have been consistently directed to the *most acute cases* of violence. This has been driven by the need to intervene to prevent further serious harm, injury, and fatality, resulting in an "inverse" pyramid, in which the required intensity of treatment drives services, rather than the potential impact of earlier and more cost-effective intervention.

In addition, trends in prevention models have identified additional levels that expand the continuum of opportunities for prevention activity. These additions include a "*primordial*" level of prevention that addresses environmental, social, behavioral, cultural, and other systemic factors identified as risk factors, protective factors, or "root causes." At the far end of the spectrum is a "*quaternary*" level of prevention that seeks to redress the risk of "disease mongering" such as overmedicalization or commercialization. This has emerged as a more innovative model, encompassing 5 levels of prevention:

**Public Health Approach to Prevention of Intimate Partner Violence: A Continuum**

A preliminary model for this guide included developing a framework applying the 5 levels of prevention to the field of DV/IPV work along a continuum. A realistic model for the prevention of intimate partner violence is one that includes opportunities for some level of prevention across the spectrum of policies, programs, and services. Prevention is an effort to alter adverse consequences and can occur at different levels. This includes intervening at the following levels: primordial, primary, secondary, tertiary, and quaternary.




This model encourages and supports *collective action* in DV/IPV work through a more intentional approach to *multi-systems, multi-agency, cross-disciplinary* efforts. In the model, a DV/IPV agency may engage in advocacy, policy development, and community engagement to amplify the work occurring at service delivery levels. The agency may partner with other agencies engaging in education to reduce the risk factors that are correlated with other types of interpersonal violence. The agency may develop more programs and services accessible to those who are just beginning to experience the problem of interpersonal violence, including increased screening and prompt intervention to disrupt emerging cycles or patterns of violence. DV/IPV agencies providing crisis response may include additional services and programs that strengthen capacity, and promote empowerment and growth post-trauma, to prevent further recurrences. In addition, DV/IPV agencies may participate in efforts to change systems of care that have had unintended negative consequences to participants.

**A New Paradigm for Prevention Work in DV/IPV: A Matrix**

Below is a "user friendly" functional model for those engaged in DV/IPV work. This work enhances the synchronicity and flow between levels of prevention and the ways in which this work is understood and practiced. In the model, primary prevention becomes ***education,*** secondary prevention becomes ***early intervention,*** tertiary prevention becomes ***crisis response,*** and the primordial and quaternary work that address systemic factors is integrated into the work of ***stabilization.***

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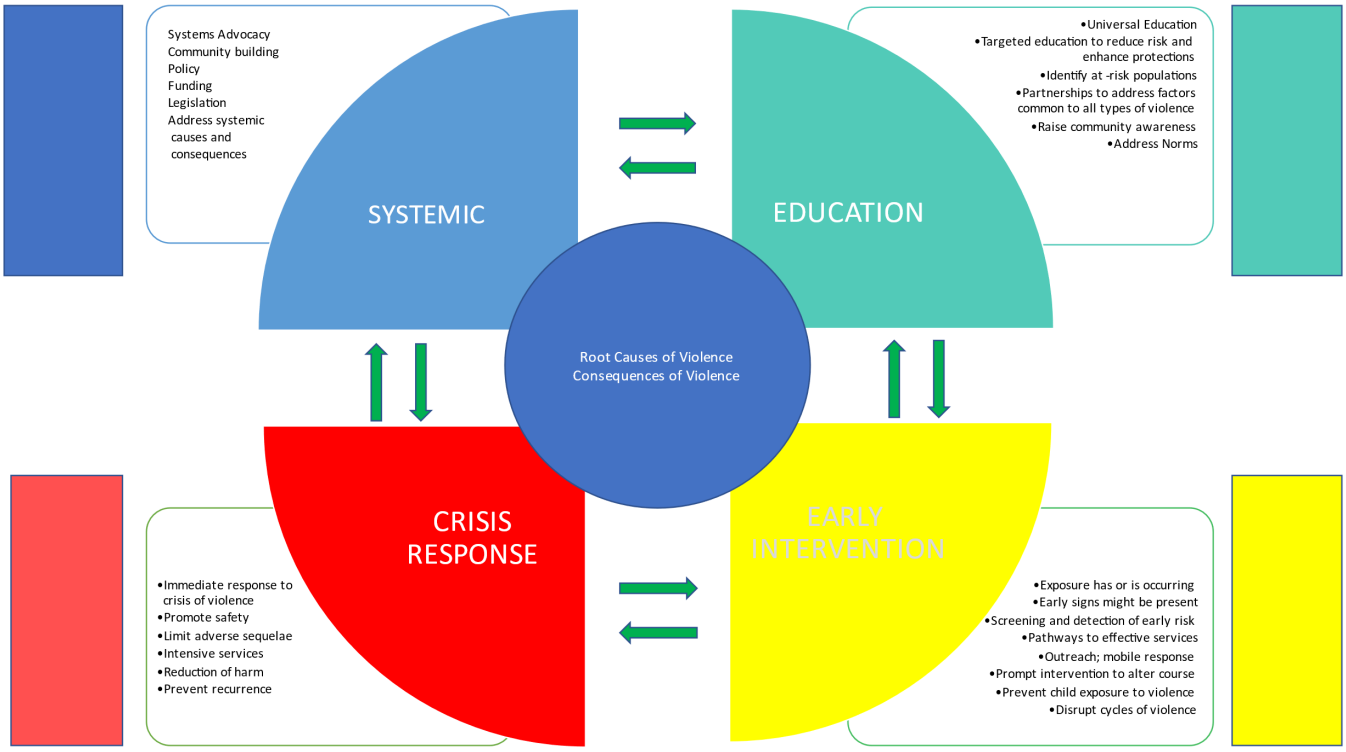


**Training 1: Bringing a Public Health Approach to the Field of Domestic Violence/Intimate Partner Violence**

**White Paper: Expanding Funding Streams for Violence Prevention in DV/IPV Services**