STRATEGIC DIRECTIONS

for the Prevention of Intimate Partner Violence in New York State

New York State IPV/Domestic Violence Primary Prevention
Five Year Plan: 2009-2014

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Original publication date: August 2010/Updated publication date: June 2013

This publication was supported by Cooperative Agreement No U17/CCU022266-01 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official view of the CDC.

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EXECUTIVE SUMMARY

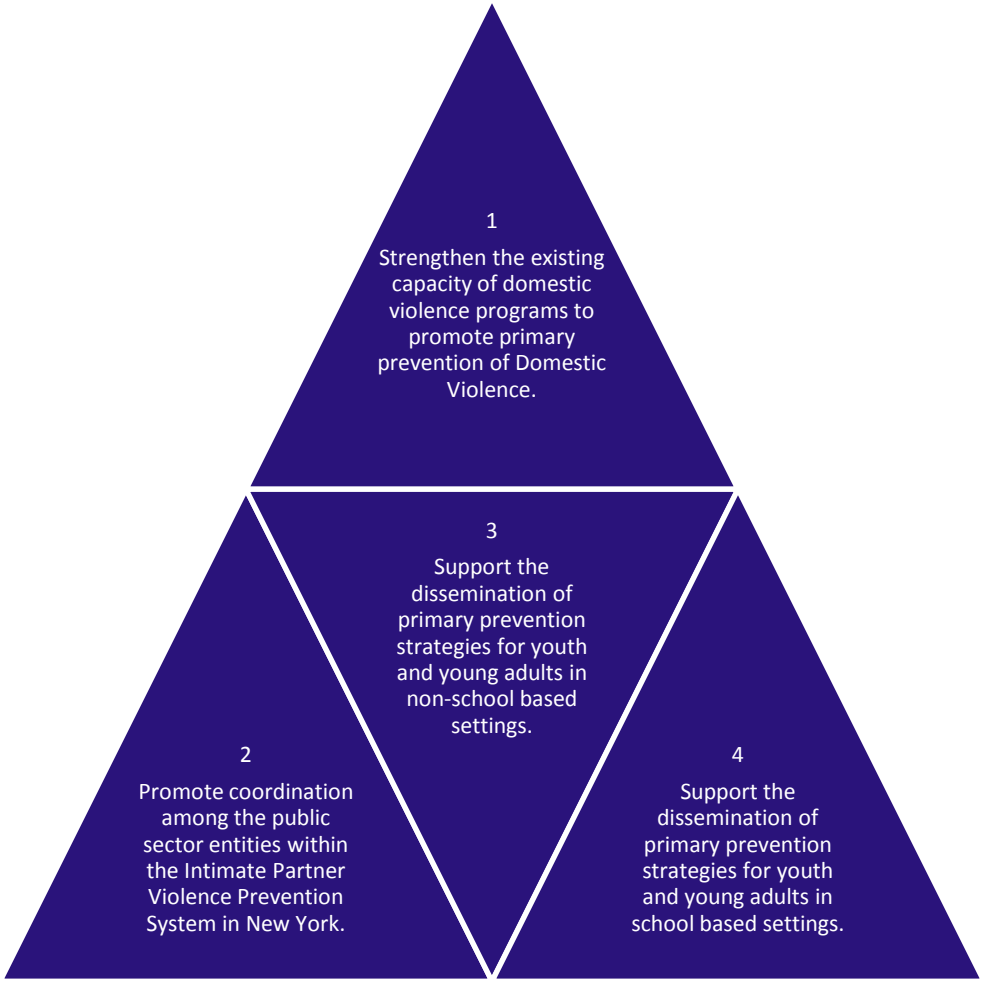
Domestic violence is a significant public health problem in the United States that is typically addressed by responding to incidents that *have* occurred by providing safety and support to the victims and by holding batterers accountable for their behavior. These very important efforts have been successful and must continue, but they should be done in conjunction with efforts to prevent first time victimization or perpetration, an approach that is referred to as primary prevention. This plan identifies, recommends, and proposes to evaluate prevention strategies for New York State level action, as well as provides a snapshot of the "state of the state" on domestic violence in New York State.

In 2006, a NYS Intimate Partner Violence Prevention Consortium (Consortium) was developed to provide state level leadership and support in challenging and reshaping the social conditions and norms that condone and promote domestic violence as well as facilitate a statewide planning process regarding the primary prevention of domestic violence. The Consortium brings together a vital mix of formal organizational collaboration along with broad community support through the inclusion of a multidisciplinary group of experienced prevention practitioners, stakeholders, and advocates.

Strategic Directions for the Prevention of Intimate Partner Violence in New York State is the result of the Consortium's planning process and was originally published in 2010. This is an updated version that reflects current data and knowledge gained throughout the process of implementing the plan. Cognizant of the fact that domestic violence is an issue that calls for community-oriented approaches to stopping abuse before it can begin, this plan is informed by extensive stakeholder interviews; assessment of community profile data including the scope of the problem of domestic violence in New York State; and the review of the existing approaches to prevention used in community contexts throughout New York State. The compilation of this information led to four strategic directions that construct a blueprint of goals, creating a comprehensive approach to preventing domestic violence in New York. The four strategic directions are:

- Δ Strengthen the existing capacity of domestic violence programs to promote primary prevention of domestic violence.
- Δ Promote coordination among the public sector entities within the Intimate Partner Violence Prevention System in New York.
- Δ Support the dissemination of primary prevention strategies for youth and young adults in non-school based settings.
- Δ Support the dissemination of primary prevention strategies for youth and young adults in school based settings.

4 Strategic Directions for New York State's Domestic Violence Prevention Plan



The development of this plan would not have been possible without support from the Centers for Disease Control and Prevention National Center for Injury Prevention (CDC), DELTA Project Staff, the thirteen state domestic violence coalitions that participated in DELTA, Prevention Consortium members and local domestic violence programs and their community partners that work so tirelessly to create innovative, effective prevention programming designed to change the norms in their communities to one of intolerance for intimate partner violence in any form. It has been an honor to work closely with these partners and learning with and from them each day.

INTRODUCTION

Background

Since its inception in 1978, the New York State Coalition Against Domestic Violence (NYSCADV) has worked to create and support the social change necessary to prevent and confront all forms of domestic violence. NYSCADV's vision of the future is that the collective voices of survivors and advocates will strengthen public and private response and prioritize domestic violence as a human rights issue. As a statewide membership organization, NYSCADV achieves our mission through activism, training, prevention, technical assistance, legislative development and advocacy, and leadership development. NYSCADV promotes best practices and broad-based collaboration integrating anti-oppression principles in all our work.

Consistent with this mission and vision for our work, NYSCADV participated in the **D**omestic **V**iolence **P**revention **E**nhancement and **L**eadership **T**hrough **A**lliances (DELTA) Project from October 2002 through January 2013. The DELTA Project is a collaboration with the CDC, thirteen state domestic violence coalitions throughout the country, and over fifty local domestic violence programs. The DELTA Project was designed to increase the prevention capacity of local Community Coordinated Response (CCR) teams, domestic violence program staff, Coalition staff, and partner organizations through prevention-focused learning exchanges which were made possible with funding from the CDC.

Participation in the DELTA Project has increased the capacity of NYSCADV to support domestic violence programs and community members to engage in primary prevention to address the problem of intimate partner violence. One of the NYSCADV's core operating assumptions is that meaningful and lasting change happens at the community level. As such, our efforts focus on supporting communities to find effective and locally relevant methods for organizing and mobilizing to effect change.

Purpose of This Report

Domestic violence is a significant public health problem in the United States. Most responses to domestic violence have focused on addressing the problem after it occurs — shelter for victims and their children, support groups, employment counseling, advocacy, legal changes, legal services, batterer intervention programs, etc. Many of these efforts have proven to be very successful in responding to the needs of survivors and supporting communities' efforts to hold offenders accountable. Time, resources, and the unremitting demand for intervention have inhibited progress in the development and implementation of programs that would prevent domestic violence before it occurs. The purpose of the plan outlined in this document is to initiate, enhance, and expand statewide primary prevention initiatives, resulting in Strategic Directions for the Prevention of Intimate Partner Violence in New York State.

Defining Domestic Violence & Intimate Partner Violence

First, it is important to define the issue that we are trying to prevent. Domestic violence is a *pattern* of coercive behavior or tactics that is culturally learned and socially condoned. It can include physical, sexual, psychological, economic, and other forms of abuse, and is perpetrated by one person against their intimate partner for the purpose of establishing and maintaining control over that person. For the purposes of this document, domestic violence and intimate partner violence are synonymous.

Defining Prevention – The Public Health Approach to Primary Prevention

The CDC uses a public health perspective to categorize a continuum of prevention: primary, secondary and tertiary. Primary prevention approaches take place before domestic violence has occurred to prevent first time victimization or perpetration. Secondary prevention attempts to prevent violence from happening again and addresses the short-term consequences, while tertiary prevention focuses on the long term effects of IPV and addresses them through providing ongoing support and healing of victims and efforts to hold abusers accountable. Many secondary and all tertiary prevention efforts can be called intervention. Thus primary prevention does not replace intervention but instead complements it. Communities must have safety and support for victims and accountability for abusers in place in addition to working on primary prevention. This will be discussed in greater detail in the *Evidence-Based Strategies, State & Community Context, Capacity* section on page 35 of this report.

Planning Process

In 2003, as part of the DELTA Project, NYSCADV convened a statewide advisory committee to assist with DELTA and, in 2006, that committee became the NYS Intimate Partner Violence Prevention Consortium (Consortium) that would undergo a comprehensive Intimate Partner Violence (IPV) prevention planning process.

Evidence-Based Strategies

The New York State IPV prevention planning process used an empowerment evaluation approach called Getting to Outcomes (GTO)[1], to ensure that a thoughtful and realistic state-level IPV Prevention Plan was developed. In addition, this plan was guided by the four phases of the public health model (The Centers for Disease Control and Prevention [CDC], n.d.a.)

The Public Health Model

And, recognizing the interrelation between people and their environments, the Social Ecological Model was used to inform the development of this plan. The Social Ecological Model provides a framework that is built on the multidimensional and complex aspects of people's lives and identifies that behaviors do not occur in a vacuum. The four levels of the model – individual, relationship, community and society – are connected and reinforce each other, while representing separate, but complementary avenues through which to prevent domestic violence (CDC, n.d.b.). Traditionally, efforts for prevention have naturally gravitated toward individual and relationship level activities. This plan will direct the states prevention efforts to target the community and societal levels of the Ecological Model. Identifying strategies and engaging at community and societal levels of change is more complex and takes dedication, creativity and time.

- Δ **Individual** level strategies are directed at individuals to change their social/cognitive skills and behaviors.
- Δ **Relationship** level strategies seek to change people in close interpersonal relationship with your priority individuals.
- Δ **Community** level strategies seek to change environments in common social settings, groups or organizations through changing attitudes, policy, training and interpersonal skills of people in these settings.
- Δ **Societal** level strategies seek to change macrosystems such as media, legislation, and economic opportunity.

[1] Getting to Outcomes is an empowerment evaluation model that leads the users through a 10 question process that incorporates the basic elements of program planning, implementation, evaluation, and sustainability. Asking and answering these questions helps achieve results in interventions (e.g., programs, policies, etc.) and demonstrates accountability to such key stakeholders as funders (Wandersman, Imm, Chinman, & Kaftarian, 2000).

Critical elements of the primary prevention of domestic violence include:

- Δ directing efforts to the general population instead of working solely with victims, their children and abusers, and
- Δ comprehensive approaches that address individual as well as community and system change in order to generate and reinforce new social norms.

The Consortium – Recruitment.

NYSCADV staff, especially the NYSCADV Prevention Integration Team, worked closely with NYSCADV's Director of Prevention Programming to review the membership representation of a previously existing advisory committee to ensure that the racial, ethnic and gender diversity of the state was reflected in this committee's membership. To ensure this diversity, members who advocate for the needs of those communities, particularly communities of color, the LGBTQ community and persons with disabilities were recruited to fill areas of need within the membership. This diversity gave voice to the needs of traditionally marginalized communities. Consistent with research consistently showing that the majority of IPV is perpetrated by men, NYSCADV also ensured that the Consortium included individuals who could inform the development and implementation of prevention activities and programs directed at men and boys. As a result, the Consortium is comprised of staff from relevant state agencies such as NYS Department of Health, which is the state agency that oversees funding to rape crisis programs and the statewide plan for the prevention of sexual assault; staff from the NYS Office for the Prevention of Domestic Violence, which is an executive level state office dedicated to improving the State's response to domestic violence; to a variety of non-profit organizations that represent the various needs of victims of domestic violence.

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- Sylvia Perez

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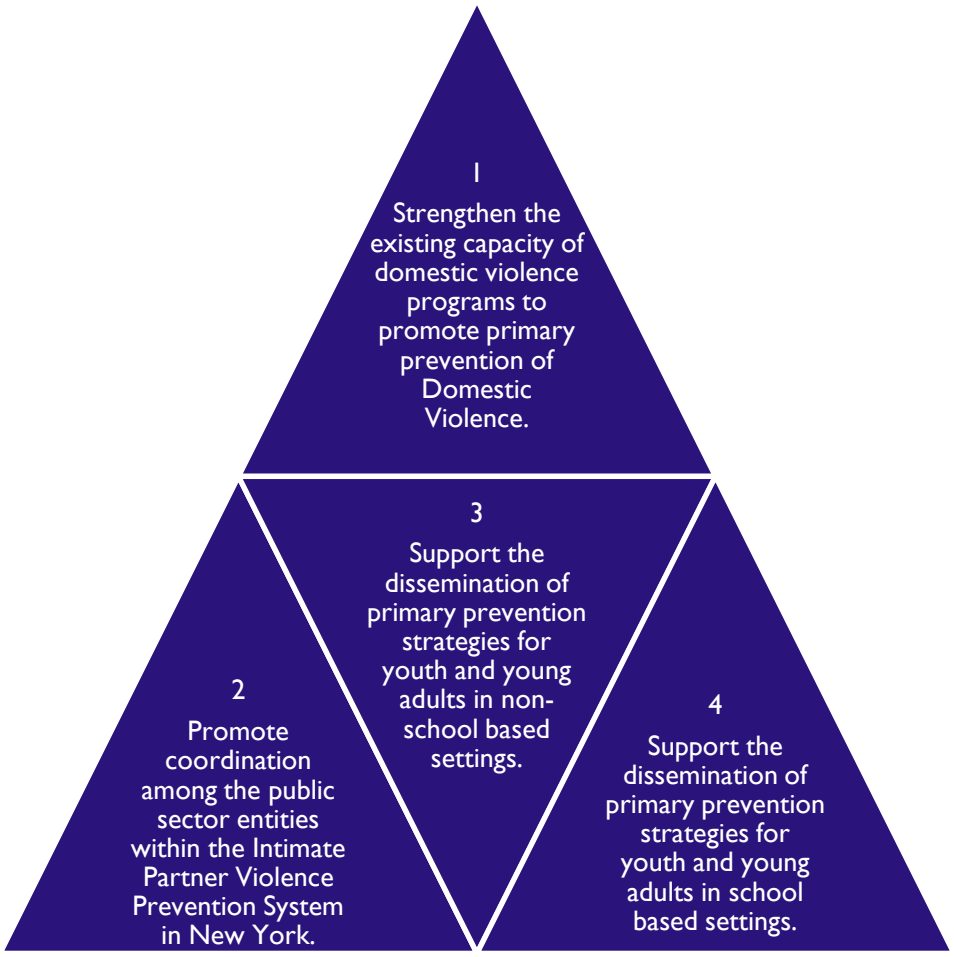
The Result

The results of this work are goals, strategies, and activities related to the primary prevention of intimate partner violence that will be implemented across New York State as well as a shared prevention vision that guides these efforts. The goals, strategies and activities outlined in this plan are derived from four sources: 1) multiple stakeholders involved in diverse work across the state; 2) community profile data about New York; 3) literature related to the prevalence of domestic violence; and 4) existing approaches to prevention used in community contexts. Extensive stakeholder interviews of Consortium members, as well as other allies and partners, assessing current prevention system capacity were central to the development of this plan. These interviews assisted NYSCADV in assessing individual member's level of prevention knowledge and capacity, as well as evidence-informed prevention strategies that would be critical to state level planning.

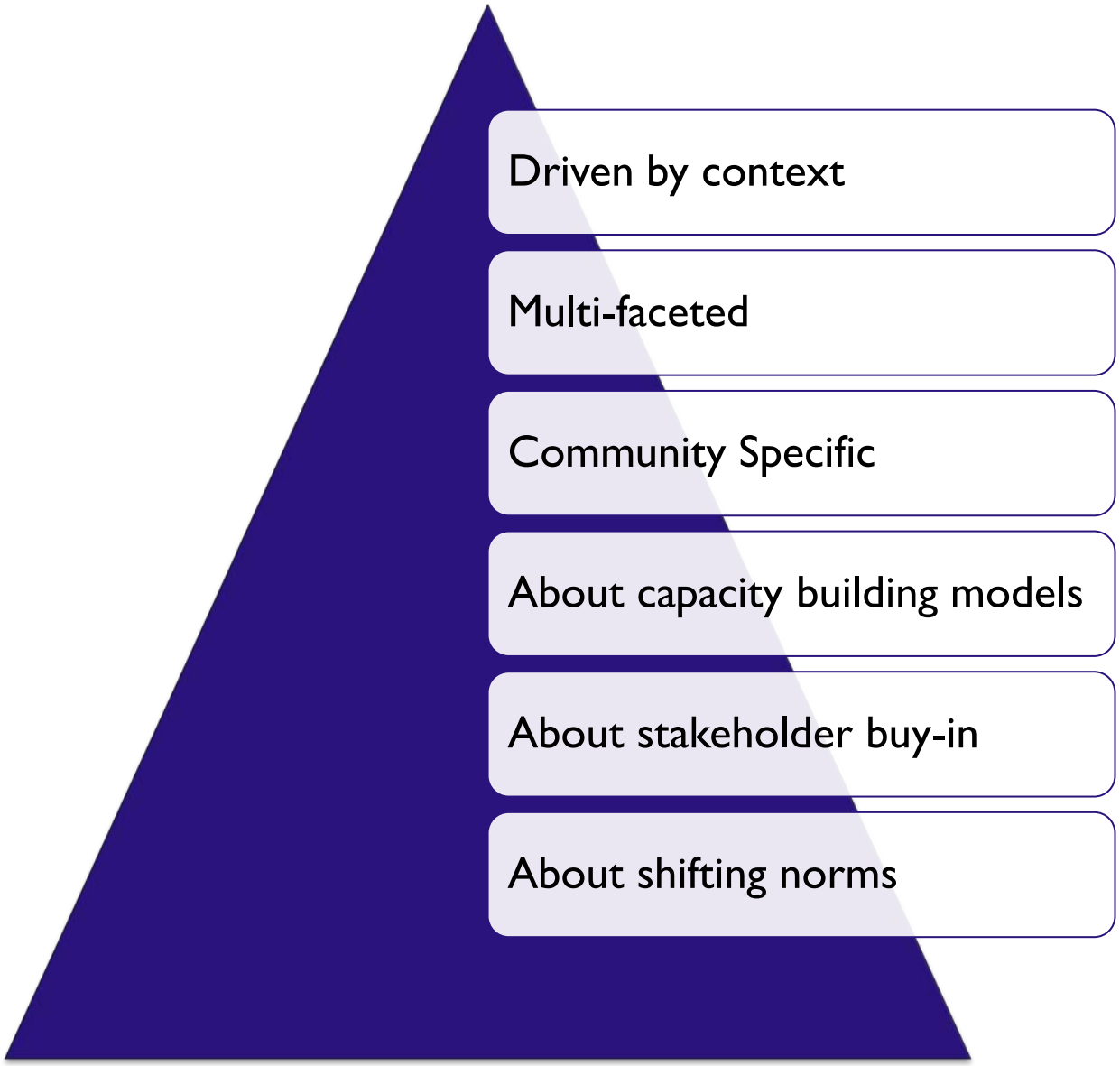
Goals, Strategies and Activities

The goals, strategies and activities related to the primary prevention of intimate partner violence can be summarized into the four strategic directions for New York State's domestic violence prevention plan:



Shared Prevention Vision

Prevention programs need to be:



NEEDS AND RESOURCES ASSESSMENT

New York State Profile

Consistent with the first phase of the public health model, the goal of creating this state profile was to inform our state prevention plan by identifying universal and selected groups that may benefit from tailored prevention efforts. The state profile helps by identify untapped resources and opportunities for intervention, including universal prevention and prevention targeting specific audiences.

Population and Geography

According to the 2010 Census data, New York State is the third most populous state in the country (behind California and Texas, respectively) with a population of 19,378,102 people, which is an increase of 2.1 percent from the year 2000 U.S. Census data (Mackun & Wilson, 2011). Except for a decline in population between the 1970 and the 1980 U.S. Census, the population of New York State has been gradually increasing. The majority of the State's population – 87.87%, resides within urban areas, which is defined as an area with 50,000 people or more (U.S. Census Bureau, n.d.a.). The New York metropolitan area (which includes Northern New Jersey) is again the most populous metropolitan area in the country, and has been one of the top three urbanized areas consistently since 1950 (Mackun & Wilson, 2011). There are 62 counties in New York State, 5 of which are consolidated under one City Government of New York City. The other 57 counties "are functioning governmental units, each governed by a board of supervisors, county legislature, board of representatives, a legislative board, or a board of legislators" (U.S. Census Bureau, n.d.b.). There are eight federally recognized American Indian reservations, one tribal designated statistical area and two recognized reservations (U.S. Census Bureau, n.d.b.).

While the overall population of the state has been moderately increasing, there is a clear trend of population loss in all 61 of New York State's cities except for New York City. This population loss in the cities is correlating with population increase in towns. According to a report published by the New York State Comptroller's Office assessing population trends until the year 2000, town populations have increased by 16% (Hevesi, A.G., n.d.). The cities that experienced the most dramatic loss of population are those in Western New York and the Mohawk Valley. Of the "Big Five" cities in New York State, Buffalo's population declined the most between 1970 – 2000, with a 36.8% decrease, followed by Rochester with 25.7%, Syracuse with 25.3%, and Yonkers with a 4% decrease in population (Hevesi, A.G., n.d.). During this same time, New York City's population increased 1.4% (Hevesi, A.G., n.d.). The 2010 Census data reflects this trend as it indicates that Watertown, NY, which is a suburb of Syracuse,

was newly classified as an urbanized area as of the 2010 census (U.S. Census Bureau, n.d.a.). These shifts in population create shifts in socioeconomic composition and revenue flow. The Comptroller's report states that due to the "middle-class exodus," cities in turn "tend to have greater levels of poverty, higher levels of vacant housing, a greater percentage of female headed households with children, and a higher percentage of adults with less than a high school diploma when compared to surrounding suburban neighborhoods" (Hevesi, A., n.d.).

- Δ Counties experiencing rapid population growth may encounter different challenges, and have different resources, than Counties that are experiencing little or no growth, or loss of population.
- Δ All strategies developed for this prevention plan must be cognizant of the needs of communities from urban, suburban and rural communities and able to change to meet the unique needs of each of these geographic locations.

Economic Conditions

When assessing the economic status of New York State's residents, the median income for full-time, year around workers over the age of 16 from 2010 – 2011 was $50,388 for males and $42,113 for females (U.S. Census Bureau, 2011). Approximately 34% of the population with earnings make under $34,999 and 25% make over $75,000. The majority of New Yorkers who receive public benefits receive Social Security Income (29%) and other retirement income (17.3%), where as 15.2% of the population receive food stamps, 6.3% receive Supplemental Social Security Income, and 3.4% receive cash assistance (U.S. Census Bureau, 2011).

The industry clusters employing the greatest number of people are health care and social assistance; retail; finance and insurance; manufacturing; and professional, scientific, and technical services, respectively. The relocation of jobs to suburban locations has led to a general worsening of conditions in cities that persists today. Likewise, much economic activity, notably manufacturing and the headquarters of corporations, also moved to the suburbs. When compared to surrounding towns, cities tend to have greater levels of poverty, higher levels of vacant housing, a greater percentage of female-headed households with children, and more adults lacking a high school diploma. In New York State, 79.1% of persons 25 years and older graduated from high school and 14.6% of residents lived below poverty. In NYC, 72.3% of persons 25 years and older graduated from high school and in NYC, 21.2% of residents lived below poverty (New York City Department of Health and Mental Hygiene [NYC DOH], 2008).

- Δ Although domestic violence is a significant cause of injury and death for women at all income levels, women living in poverty are at higher risk of domestic violence.

Gender and Age

Females comprise a slim majority at 50.8% of the State's population; males comprise 49.2% of the population (Howden & Meyer, 2011). The median age of the state's population is 37.2, which has been increasing since 1960. Persons age 18-44 are the majority age group as of the 2010 U.S. Census (36.5%), followed by those age 45 to 64 years (26.4%), those under the age of 18 years (24%), with those age 65 years and over constituting the smallest portion of the State's population (13.0%) (Howden & Meyer, 2011).

A trend that occurred between the 1990 and 2010 census is that other than New York City, the number of young adults age 20-34 has been declining in New York State. As of 2010, the median age in New York City is 35.5, the median age of the Downstate suburbs is 39.9 and the median age of Upstate is 40.0 (McMahon, E.J., Scardamalia, R., 2012).

- Δ The prevention plan will need to address various age groups.

Race and Ethnicity

97.3% of responders to the 2010 U.S. Census identified as one race - 65.3% White; 15.6% Black or African American; 8.6% identified as other, 7.4% Asian, .3% American Indian and Alaska Native; and less than .1% identified as Native Hawaiian and other Pacific Islander. Regarding Hispanic or Latino identification, 18% identified as Hispanic or Latino and 57.8% identified as White alone. The white, Non-Hispanic population has been declining statewide, with the greatest decline Downstate and the Black, Non-Hispanic population has declined as well, but only minimally. A shift in trend with this population is that this population grew by nearly 10% Upstate while experiencing a loss of 1% Downstate (McMahon, E.J., Scardamalia, R., 2012). In addition, the Asian, Non-Hispanic population and the Hispanic/Latino population both increased Upstate by approximately 50% from 2000 to 2010. These Races also increased Downstate by approximately 34% and 16%, respectively (McMahon, E.J., Scardamalia, R., 2012).

- Δ There are people of color in all areas of the state, but population density varies widely, and the pattern of variation is unique for each group. Prevention planning needs to be flexible to reach isolated sub-populations, and areas of concentration.
- Δ It is important to be aware of race and ethnicity as different dimensions of identity.

Immigration and Language Proficiency

New York State has a unique history of immigration resulting from the very nature of Ellis Island and the iconic Statue of Liberty being located in New York Harbor. Over 12 million immigrants entered the United States through Ellis Island from 1892 - 1954 (Ellis Island, Inc., n.d.). Currently, 22% of New York State residents are foreign-born (U.S. Census Bureau, 2011). This proportion has been on the rise in recent years. The regions from which foreign born residents come from in New York State differ dramatically when viewed in an "Upstate/Downstate" perspective. According to a report published by the Federal Reserve Bank of New York, more than 50% of the foreign-born people in New York City are from Latin America, while only 13% of people in Upstate New York are from Latin America. Instead, in Upstate New York more than 40% of the foreign-born population is from Europe, "and include both long-time U.S. residents from countries such as Germany and Poland as well as newer arrivals from Eastern Europe and former Soviet states" (Orr, J., Wieler, S., Pereira, J., 2007).

Language proficiency is important to be aware of as it can impact an individual's access to services and information. Currently there are "2.5 million New Yorkers who have limited-English proficiency which means that they so not speak English as their primary language and have limited ability to read, speak, write or understand English" (Cuomo, A., 2011). Because of this, New York State's Governor Cuomo enacted Executive Order 26 on October 6, 2011 directing Executive State agencies that provide direct service to translate all vital documents into the 6 most common languages in the state - Spanish, Chinese, Italian, Russian, French, and French-Créole.

Broad racial and ethnic categories can mask great diversity in cultural and family history. For example, the Hispanic category includes people who identify their origins are Mexican, Puerto Rican, Cuban and various Central and South American countries. Further, there is great diversity of immigration history and acculturation.

- Δ Strategies designed to prevent domestic violence, as well as services and access to resources, must be offered in a variety of languages to accommodate New York's new immigrant populations.

Culture

Clearly, New York is a diverse state. In addition to the diversity created by its geography, demographics, population distribution, and socio-economic status of its residents, one must take into account the vast cultural diversity of the state. Culture is defined as "shared behaviors, meanings, symbols and values from one generation to the next" (Goldenberg) and it is not limited to just ethnic or

racial identity. In addition to race and ethnicity, culture includes, but is not limited to, intersections of age, sex, gender, sexual orientation, class, immigration status, and disability (Warrier, 2005). Culture is not fixed in nature or time and an individual person may identify with many cultures at one time and associations can vary or remain static over a lifetime.

- Culturally competent prevention strategies must reflect that individuals may identify with many cultures and that their association may or may not be static over time.

Scope of the Problem – Intimate Partner Violence

Although the CDC emphasizes the need for consistent definitions of intimate partner violence (IPV) to effectively "monitor the incidence of IPV and examine trends over time" (CDC, n.d.b.), there have been differing definitions in research and data collection throughout the years as it relates to those affected. For example, New York State's legal system includes non-intimate partner family members related by blood or marriage in their definition of domestic violence. Therefore under this definition, siblings, parents, children, cousins, aunts and uncles are included. For the purposes of the work outlined in this strategic plan, domestic violence or intimate partner violence is focused solely on violence that occurs in an intimate or formerly intimate relationship. Intimate refers to either a current or former partner or spouse, boyfriends, girlfriends, lovers, dating partners, etc. (NYC DOH, 2008). But the data used to assess the scope of the problem may not always strictly adhere to that definition.

What is consistent are the behaviors that constitute the acts of this abuse. Abuse can include physical abuse, sexual abuse, psychological abuse, abuse of pets, property destruction, stalking, and violence towards others, among many other tactics of abuse. Examples of physical IPV include the use of weapons, slapping, kicking, and pushing. Forced or unwanted sexual acts are included in sexual IPV. In fact, tactics frequently used by abusers fall under the definition of sexual or reproductive coercion. Threatening to hit or to use weapons, continually criticizing, and controlling access to family, friends, work, and money are examples of psychological IPV. What can differ are the dynamics behind the power and control.

Intimate partner violence is typically chronic even though the frequency of various types of violence may wax and wane over time. However, there is a constant potential for physical and sexual assault, including severe injury. The memory of past violence and the threats of future violence remind survivors of that constant potential. Violence and abuse, and threats thereof, are used by batterers to control, dominate and punish their victims. The intended and actual result of fear, intimidation, and

coercion as experienced by victims are distinguishing hallmarks of intimate partner violence from other forms of violence.

The CDC's National Center for Injury Prevention and Control launched the National Intimate Partner and Sexual Violence Survey (NISVS) in 2010. Initial findings indicate that in the United States:

• More than 1 in 3 women (35.6%) • More than 1 in 4 men (28.5%)	experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
• About 1 in 4 women (24.3%) • About 1 in 7 men (13.8%)	have experienced severe physical violence by an intimate partner (e.g., hit with a fist or something hard, beaten, slammed against something) at some point in their lifetime.
• An estimated 10.7% of women • An estimated 2.1% of men	have been stalked by an intimate partner during their lifetime.
• Nearly 3 in 10 women • Nearly 1 in 10 men	in the United States have experienced rape, physical violence, and/or stalking by an intimate partner and reported at least one impact related to experiencing these or other forms of violent behavior in the relationship (e.g., being fearful, concerned for safety, post traumatic stress disorder (PTSD) symptoms, need for health care, injury, contacting a crisis hotline, need for housing services, need for victim's advocate services, need for legal services, missed at least one day of work or school).

(Black, et al., 2011)

These findings clearly show that a significant number of people in the United States experience some form of violence and intimidation at the hands of an intimate partner.

Female Victims of Intimate Partner Violence

The data collected through NISVS so far has concluded that "women are disproportionally affected by sexual violence, intimate partner violence and stalking" (CDC, 2011). This startling fact has remained consistent over time considering that Strauss, Gelles and Steinmetz reported in their now classic book published in 1980, *Behind closed doors: A survey of family violence in America,* that 16% of the 2,143 women to whom they conducted a national telephone survey reported physical partner violence in the past year—a push, shove, hit or more severe violence—while 28% reported physical violence at some time in their marriage (Straus, Gelles, & Steinmetz, 1980). Twenty years later, the National Institute of Justice and the CDC conducted a nationwide survey and found that:

- 22% of women reported physical assault by a current or former spouse, cohabiting partner, boyfriend or girlfriend, or date in their lifetime;
- 17.6 % reported a completed or attempted rape at some time in their life. Of this group, 32.4% were between age 12 and 17 when they experienced a first attempted or completed rape, and 21.6% were younger than age 12;
- 30.4% of the women who had married or lived with a man as part of a couple reported being raped, physically assaulted, and/or stalked by a husband or male cohabitant (Tjaden & Thoennes, 2000).

These trends can also be seen in homicide statistics as "female murder victims (41.5%) were almost 6 times more likely than male murder victims (7.1%) to have been killed by an intimate" (Cooper & Smith, 2011, p. 10).

Women's experience of violence is not confined to the United States. Analysis of violence against women from an international perspective highlights that this is a significant human rights issue. When reviewing the range of violent acts against women such as violence against women in custody; acid burning and dowry deaths; honor killings; female genital mutilation (FGM); human rights violations based on actual or perceived sexual identity; gender related asylum; and domestic violence, it is not surprising that Amnesty International states that:

> *"Violence against women is a violation of human rights that cannot be justified by any political, religious, or cultural claim. A global culture of discrimination against women allows violence to occur daily and with impunity"* (Amnesty International, 2005, p. 2).

The World Health Organization (2005) conducted a study of over 24,000 women from 15 sites in 10 different countries found that up to 71% of the women surveyed experienced physical or sexual violence committed against them by an intimate partner. There were vast ranges in these percentages

across the 15 sites with women in Japan being the least likely to experience intimate partner violence "while the greatest amount of violence was reported by women living in provincial (for the most part rural) settings in Bangladesh, Ethiopia, Peru, and the United Republic of Tanzania" (World Health Organization, 2005, p. 5).

Male Victims of Intimate Partner Violence

Data shows that men do experience intimate partner violence committed against them, just at rates lower than those for females. Tjaden & Thoennes (2000) found that "7.6 percent of the surveyed men said they were raped and/or physically assault by a current or former spouse, cohabiting partner, or date at some time in their lifetime" (Tjaden & Thoennes, 2000, p. iii) as compared to the 25% of the women surveyed who indicated experiencing the same types of violence committed against them by an intimate partner. This same study found that assaults by an intimate partner toward men were less chronic then those committed against women (men experienced an average of 4.4 assaults by the same partner and women experienced 6.9 physical assaults by the same partner) and less severe with 41.5% of women reporting being injured as compared to 19.9% of men reporting that they were injured (Tjaden & Thoennes, 2000). The more recent NISVS data shows that more than 28.5% of men "in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime" (Black, et al., 2011, p. 2), compared to 35.6% of women.

Assessing the Victimization Data in Light of Type of Intimate Relationship

Clearly women are experiencing intimate partner violence committed against them at a much higher rate than men, but are they all being victimized by men? And, are all men who are being victimized by an intimate partner being victimized by women? Analysis of this victimization data requires that we not assume that all intimate relationships are heterosexual.

Domestic Violence and Lesbian, Gay, Bisexual and Transgender People

There are fewer studies of domestic violence among lesbian and gay partners, and most are based upon smaller and less systematic samples. In a convenience sample of 213 gay men researcher, Susan Turell found that 58% of the men reported being physically assaulted by a male partner or ex-partner at some time, and 11% reported being sexually assaulted (Turell, 2000). In a convenience sample of 250 lesbian and gay women Turell found that women reported similar rates of physical (56%) and sexual (13%) violence by a female partner or ex-partner. In addition, Tjaden & Thoennes' (2000) nationwide survey found that 11% of women who had lived with a woman as part of a couple reported rape, physical assault, and/or stalking by a female cohabitant.

Halpern and colleagues surveyed 117 adolescents age 12-21 who reported exclusive same-sex intimate relationships, and found that 11% reported experiencing physical IPV in a same sex relationship—9% of males and 13% of females (Halpern, Young, Waller, Martin, & Kupper, 2004). Although there is clearly a need for additional research in domestic violence in LGBT populations, men and women in same-sex relationships seem to experience domestic violence at rates comparable to women in heterosexual relationships.

While rates of intimate partner violence among the LGBT population are generally considered to be the same as in heterosexual relationships, issues of power and control can take on additional dimensions in a same-sex relationship. LGBT victims often report that societal homophobia and heterosexism are used as tools of power and control over them. Abusers often threaten victims with "outing" them to family or employers and coworkers. Abusive partners also use children as leverage, such as threatening to call child protective services to report that a child's mother is a lesbian and unfit to parent. Gay men report being made to feel shame that they would "allow" another man to beat them up. Transgender victims are often told they are not a "real" woman or man, that no one would believe them if they tried to report the abuse. Transgender victims and victims who are HIV positive report having medicines and hormone therapies withheld as part of the pattern of coercive control and abuse.

Further complicating same-sex victims ability to seek help are prominent deep-rooted gender stereotypes and views of masculinity that suggest only the individual viewed as more masculine on the gender spectrum can be an abuser. This notion frequently results in the arrest of the victim and causes significant revictimization. It should not be assumed that a more masculine gender expression increases propensity to abuse. Gay men who fight back are also at risk of dual arrest and issuance orders of protection against both parties. It is critical that law enforcement and service providers conduct thorough primary aggressor screenings to insure that victims are not treated as abusers, and have full access to appropriate services.

Data Linking the Sex of the Offender to the Sex of the Victim

Although data collection related to intimate partner violence has been inconsistently collected and tracked over time, there certainly has been a push for uniformity in collection which has led to more descriptive data. Data typically is related to victim characteristics, some data is related to offender characteristics but few data sources link the sex of victims to the sex of their offenders which leaves room for debate regarding interpretation. NISVS took steps toward changing this by identifying the sex of both the victims and the perpetrators who committed sexual violence and stalking but did not do so for the data that they collected specifically on intimate partner violence. Even so, inferences can be made from the sexual victimization data and the stalking data. First, the data for both of these victimization

categories show that the majority of women knew the person who raped[2] them – 51.1% of the rapes were committed by and intimate partner[3] and 40.8% were committed by an acquaintance[4] where as males reported being raped by an acquaintance (52.4) or by a stranger (15.1%). This data showed that males were the perpetrators against females in 98.1% of the rapes recorded and in 92.5% of sexual violence acts other then rape[5] (Black, et al., 2011). Similarly, the majority of males who were raped were raped by male perpetrators (93.3%) but the perpetrators of other sexual violence against males were females – "being made to penetrate (79.2%), sexual coercion (83.6%) and unwanted sexual contact (53.1%)" (Black, et al., 2011, p. 24). These crimes were committed by either an intimate partner (44.8%) or an acquaintance (44.7%). The stalking data shows that the majority of female stalking victims were stalked by a current or former intimate partner (66.2%) and 82.5% of the perpetrators were male and males were stalked by either a current or former intimate partner (41.1%) or an acquaintance (40.0%). The perpetrators of stalking against male victims was almost equally divided between females (46.7%) and males (44.3%).

Experiential Differences Between the Sexes When Victimized by an Intimate Partner in Heterosexual Relationships

In some other surveys of women and men in the general population, men have reported rates of physical violence that are similar to rates reported by women. The rate of physical violence reported by men in these general population surveys has led some people to argue that domestic violence is as equally serious a problem for men as it is for women. However, this conclusion is not supported by a thoughtful evaluation of all scientific evidence, including studies of men and women seeking services for domestic violence and crime statistics.

Many studies of men and women who seek services for domestic violence have compared the experiences of both sexes who report physical violence by their opposite-sex partners. The experience of women in these clinical populations is dramatically different from men:

- Women report being frightened and feeling threatened by their male partner's violence, whereas men do not report being frightened or threatened but do report being amused and irritated.

[2] Rape is defined in NISVS as "completed forced penetration, attempted forced penetration, and completed alcohol/drug facilitated penetration" (Black, et al., 2011, p. 18).
[3] Intimate partner is defined by the CDC as a current or former partner or spouse in either heterosexual or same-sex relationships and does not require sexual intimacy (Centers for Disease Control and Prevention, n.d.).
[4] Acquaintance "includes friends, neighbors, family friends, first date, someone briefly known and people not known well" (Black, et al., 2011, p. 22).
[5] Other sexual violence is defined in NISVS as "made to penetrate, sexual coercion, unwanted sexual contact, non-contact unwanted sexual experiences" (Black, et al., 2011, p. 18).

- Women report using violence for self-protection or retaliation, while men report using violence to punish, dominate and control their partner.
- Men use the most severe forms of violence (assault with a gun or knife; beating; strangulation; etc.) at a much higher rate than women.
- Women are injured more frequently and more severely by their partner's violence, while men are injured less frequently and less severely.

In the vast majority of intimate heterosexual relationships in which physical violence is perpetrated, women are the primary victims and men the primary perpetrators even though men frequently report experiencing partner violence on surveys. Atypically, for a very small percentage of heterosexual relationships, men are primary victims and report experiencing fear, control, punishment and injury. While all victims of interpersonal violence deserve support, from a public health perspective, the risk factors remain low for men in heterosexual relationships to be victims of domestic violence.

When we examine men's exposure to violence through the lens of public health and prevention science, we find that men are much more likely to be physically or sexually assaulted by male friends, male acquaintances, and male strangers than by female partners. This is confirmed by Tjaden & Tohennes (2000) who examined adult women's and men's experience of violence:

- 64% of women who reported rape, physical assault or stalking since age 18 *were victimized by a current or former partner*.
- 84% of men who reported rape, physical assault or stalking since age 18 *were victimized by a non-partner.*

National crime statistics also support the conclusion that women are at much higher risk of domestic violence than men (Fox & Zawitz, n.d.). Between 2001 and 2005 women were 4 times more likely than men to report a non-fatal violent assault by an intimate partner - 4.2 per 1,000 women per year vs. 0.9 per 1,000 men.

- Non-fatal violent assaults:
    - 21.5% of assaults reported by women were perpetrated by an intimate partner,
    - 3.6% of assaults reported by men were perpetrated by an intimate partner.
- Homicides - while eleven percent of all murder victims were killed by an intimate partner:
    - 30% of female homicide victims were killed by an intimate partner,
    - 5% of male homicide victims were killed by an intimate partner.

Furthermore, over the past 20 years the proportion of female murder victims killed by an intimate partner has been increasing while the proportion of male murder victims killed by an intimate partner has been decreasing.

When all the evidence is weighed, from national surveys, studies of clinical populations, and review of crime statistics, one can make a solid, public health argument for focusing domestic violence prevention efforts upon preventing men's partner violence against women. There is no scientific support for the idea that men are common victims of domestic violence. From a public health perspective, efforts to prevent violent injury to men should focus upon preventing men's violence against men which is perpetrated by male friends, male acquaintances and male strangers.

Sexual violence is not only common for girls and women, but is most often perpetrated by a man who is known by the woman. As reported by the *Sex in America* study, a national random telephone survey of 2,143 women, 22% of women reported "being forced, by a man, to do something sexual they did not want to do" (Laumann, Michael, & Kolata, 1994). Significantly, only 4% of the men were strangers; 9% were spouses, 46% a man the woman was "in love with", 22% a man the woman "knew well" and 19% an acquaintance. This study highlights the fact that women are most at risk for sexual violence from men that they know and these results have withstood the test of time as NISVIS found that of the women that were surveyed, only 13% of them were raped by a stranger. All other rapes were committed by an intimate partner (51%), and acquaintance (40.8%), family member (12.5%) and person of authority (2.5%)[6] (Black, et al., 2011).

Scope of the Problem – Intimate Partner Violence in New York

Statewide figures for intimate partner violence come from a variety of sources which must be interpreted and analyzed separately. While the true extent of non-fatal intimate partner violence is unknown, data does indicate a high burden. A snapshot of recent burden in roughly 1/3 of the state, excluding New York City, documented over 10,000 non-fatal incidents of intimate partner violence. Specifically, in 2007, law enforcement jurisdictions covering part of New York State reported 10,260 intimate partner violence victimizations; 8,435 of these were among women and 1,825 were among men. In New York City, approximately 4,000 women and 900 men are treated in emergency rooms for IPV-related injuries (Halpern, et al., 2004; NYC DOH, 2006).

Survey data offer supplemental information on prevalence of intimate partner violence. Data from New York City's Community Health Survey show that 3.1% of adult women and 1.8% of adult men reported they feared their intimate partner in the past year (NYS DOH, 2006). School-based survey

[6] NSVIS clarifies that "due to the possibility of multiple perpetrators, combined row percents may exceed 100%" (Black, et al., 2011).

data indicate the past-year prevalence of dating violence among teens. In New York State, according to 2007 Youth Risk Behavior Survey data, 12.1% of high school teens reported physical dating violence. In New York City, 11.2% of students did (CDC, n.d.c.). Statewide and in New York City, this figure has been steadily increasing since 1999 (NYS DOH, 2006).

Across state and local data systems, certain groups appear to be at higher risk of intimate partner violence. In New York State, homicide data indicate higher intimate homicide rates among whites when compared to blacks. The converse held in New York City. Such comparisons for non-fatal IPV are not possible for the state. In New York City, data show that black and Hispanic women were twice as likely as women of other groups to be treated at emergency rooms and admitted to hospitals for IPV-related injuries. New York City's women living in neighborhoods of very low average income had at least twice the IPV-related hospitalization and emergency department visit rates compared to women living in higher income neighborhoods. When compared to teens and older women, 20-29 year old women were at least twice as likely to be killed by an intimate partner or to be treated at the hospital, or visit an emergency department for an IPV-related assault.

Gaps in New York's Data

A review of New York statistics on domestic violence reveals notable strengths and weaknesses in the domestic violence surveillance system in New York. The burden and trends of IPV described above do not capture every incident in the state. For several complex reasons - including shame, fear of repercussions, and denial - victims may not wish to report incidents. Therefore, these figures are likely to be underestimates. Since victims who disclose IPV to health care providers or researchers or who report IPV to the police may have different experiences from those who do not, the data summarized here may not be generalizable to all who experience IPV.

Potential Risk and Protective Factors

Struggles can emerge when discussing risk and protective factors for domestic violence because of the perception and concern that these factors, as they relate to victimization, could be victim blaming. Planning prevention strategies must include identifying and addressing biases and prejudices that might lead to focusing on a limited or stereotyped understanding of domestic violence victimization or perpetration. Reflecting back on the ***Social Ecological Model*** as primary

prevention strategies are developed, it is critical to address multiple risk and protective factors at multiple levels of the social ecology.

For the purposes of this prevention plan, the Consortium focused on the risk and protective factors that exist at the community and societal level. This is consistent with the belief that "to prevent violence against women, we must change the social norms, gender roles, and power relations that feed into violence. We must build communities' capacity to respond effectively to violence and encourage their ownership of the issue" (Flood, 2011, p. 368).

The Consortium articulated several factors that cause or are correlated with domestic violence. Due to limitations in the research, it is important to bear in mind that the relationship between many risk factors and the causes of intimate partner violence is unclear. In some cases, it is difficult to determine if the risk factor occurred prior to the intimate partner violence or as a result of the intimate partner violence or, in fact, if both the risk factor and the violence are the result of an unknown additional factor.

Risk Factor - Male Violence

Male violence must be part of the risk factor discussion because, as illustrated in the statistics above, intimate partner violence is prevalent and males perpetrate the majority of intimate partner violence. This fact is so significant that both the CDC and the World Health Organization focus their efforts to prevent intimate partner violence by addressing male perpetration. This is not to denigrate men but this awareness is necessary to develop goals, strategies, and activities that are appropriately targeted. This is consistent with research that shows "that primary prevention of violence should focus on the source of the violence, namely the perpetrators" (Rippe, 2011). Therefore, efforts to prevent intimate partner violence must focus on preventing male perpetration as well as engage men in preventing intimate partner violence because, as stated by well known activist Michael Flood:

- "largely it is men who perpetrate this violence . . .
- constructions of masculinity play a crucial role in shaping violence against women. . . and
- men have a positive role to play in helping stop violence against women" (Flood, 2011, p. 359).

Risk Factor - Unequal Power

Viewed in the social aggregate through myriad lenses, men and women have unequal power. Income disparities, occupational segregation, disproportionate representation in public and private sector leadership positions, disparate legal status, traditional and popular culture objectification of women, and more, exemplify the unequal status and valuing of men and women. These systemic and social constructs

of male power are mirrored by social constructions of masculinity that emphasize power and maintaining control, especially in relation to the "objectified other." This diminishment of women invariably leads to violence and other forms of abuse.

Risk Factor - Social Norms Supportive of Violence and Male Power

One Consortium member states: *"There is a belief that there are distinct sex roles allowing men who are abusive to abuse at will and with justification."* Sexism (as characterized by negative attitudes toward women, their social roles, and their traditional gender roles) and misogyny (negative attitude towards women as a group) engender both the belief and the behavior. Violence is learned through exposure to social values and beliefs regarding the appropriate roles of men and women. Women are so often invisible to boys and men as models of how to be in relationships. Violent behavior is reinforced when peers and authorities fail to sanction batterers for using violence. Boys who witness their fathers beating their mothers are seven times more likely to batter their partners.

Within most societies, some forms of violence are more permissible than others, meaning there are fewer consequences attached to certain types of violence. Additionally, there are numerous places of overlap in the risk factors for more generalized violence and intimate partner violence. Given these two propositions, tolerance within society for various types of violence supports and reinforces the use of violence in intimate partner relationships. Since consequences for violence are often tied to the status of the group being victimized, other risk factors (such as traditional gender norms, male dominance, race, class, disability, sexual orientation and gender identity, etc.) may act in conjunction to create reduced consequences for intimate partner violence.

Risk Factor - Weak Community Sanctions Against Domestic Violence Perpetrators

A cross-cultural study of 16 societies with either high or low rates of partner violence led to the development of the "sanctions and sanctuary" framework. The lowest levels of partner abuse were found to exist in societies that had strong community sanctions against partner violence and where abused women had access to sanctuary, either in the form of shelters or family. Sanctions occurred in the form of either formal legal sanctions or where there was strong moral pressure for community members to intervene when a woman was beaten (Counts, Brown, & Campbell, 1992). The absence of community sanctions not only limits the ways in which individual offenders can be held accountable, it actually promotes community level risk factors. Without community sanctions, whether legal in nature or otherwise, social norms that support male violence and use of power are reinforced, as are the devaluing of female safety and well- being.

Protective Factors – Strong Community Sanctions and Egalitarian Norms

The contrary to many of the identified risk factors were identified as strong community sanctions and egalitarian social norms. Community sanctions and reshaping social norms are integrally related. Social norms aren't created in a vacuum. Rather new ideas and egalitarian principles are introduced when existing discriminatory social norms are challenged and corrected. For example, informal community sanctions are central to most of the initiatives that promote male allies against violence against women. The culture of tolerance and promotion of male dominance is challenged when peer sanctions and counter messages are delivered when faced with male violence against women and other examples of aggression, domination and hyper-masculinity. Other examples of protective factors that both deliver informal sanctions and introduce positive egalitarian principles abound in family, neighborhood, school, and religious community contexts, among others.

GOALS AND OUTCOME STATEMENTS

Continuing through the stages of the public health model, the Prevention Team synthesized the information gathered during the problem definition stage and the risk factor identification stage and determined four strategic directions. These were then expanded on to determine goal statements and outcome statements, which are supported by rationale, ask:

- Δ Who will change?
- Δ What will change?
- Δ How much change is realistic?
- Δ By when will change occur?
- Δ How will change be measured?

Strategic Direction 1:

Strengthen the existing capacity of domestic violence programs to promote primary prevention of Domestic Violence.

Goal Statement 1: Strengthen existing capacity of domestic violence programs to conduct primary prevention strategies.	
Who will change?	Organizations working on domestic violence
What will change?	Capacity to do primary prevention strategies
How much change is realistic?	20% increase
By when will change occur?	Five years
How will change be measured?	A survey of organizations working on domestic violence will be conducted annually to document their perception of change over time.

Rationale 1: In the book *Prevention is Primary: Strategies for Community Wellbeing* (Cohen, L., Chehimi, S., and Chavez, V., 2007), a compelling case is made that effective primary prevention practice uses the "engine" of community organizing. Community organizing initiatives are those which invite members of the general public to actively engage in work to end violence against women. This assertion is equally borne out by the experiences of the NYS DELTA Prevention Project domestic violence programs and community activists have long utilized organizing strategies with the goals of enhancing safety and achieving social justice for battered women and children. Objectives of community organizing include: 1) an expansion of the constituency of active participants in the work; 2) an articulation of a clear, universal message that each citizen can take responsibility to end this violence; and 3) transformation of the public discourse and consciousness about the causes of violence against women and the power of the community to end it (Hart, 1995). This plan seeks to expand and support

community organizing strategies used by organizations doing domestic violence work to advance primary prevention strategies to end domestic violence.

Outcome Statement 1: Domestic violence programs will conduct 20% more primary prevention activities by the end of 5 years.	
Who will change?	Organizations working on domestic violence
What will change?	Primary prevention activities
How much change is realistic?	20%
By when will change occur?	By the end of 5 years
How will change be measured?	A survey of domestic violence programs will be conducted bi-annually to document primary prevention activities and track increase in activities over time.

Outcome Statement 2: Domestic violence programs increase their capacity to conduct primary prevention activities by 30% by the end of 5 years.	
Who will change?	Organizations working on domestic violence
What will change?	Primary prevention capacity
How much change is realistic?	30%
By when will change occur?	By the end of year 5
How will change be measured?	A survey of domestic violence programs will be conducted bi-annually to document an increase in their capacity over time.

Strategic Direction 2:

Promote coordination among the public sector entities within New York's Intimate Partner Violence Prevention System.

Goal Statement 2: Enhance the coordination of public sector entities within the intimate Partner Violence Prevention System in New York by 20% in 5 years.	
Who will change?	Organizations that comprise the prevention system
What will change?	Coordination
How much change is realistic?	20% increase
By when will change occur?	Five years
How will change be measured?	A survey of organizations that comprise the prevention system will be conducted bi-annually to document collaboration, coordination and partnerships for prevention. [Baseline assessment conducted in Fall, 2008.]

Rationale 2: Numerous public sector entities are aware of domestic violence activities and initiatives regarding their subject area, and even directly contribute to or sponsor those activities. Less common is awareness regarding the domestic violence activities and initiatives of other public sector entities. Further, another subset of public sector entities does not directly engage in such activities at all. While the fact that state agencies are implementing the statutory requirement that they adopt workplace

violence policies furthers awareness of the issue, enhanced coordination is needed among public sector entities to maximize the impact of resources, commitment and talent in pursuit of intimate partner violence primary prevention.

Outcome Statement 1: The commitment and capacity of state entities to promote and coordinate primary prevention strategies locally, regionally and statewide will be increased by 10% in 5 years.	
Who will change?	State governmental entities
What will change?	Commitment and capacity to promote prevention programs
How much change is realistic?	10% increase
By when will change occur?	Five years
How will change be measured?	A survey of organizations working on domestic violence will be conducted annually to document their perception of change in state governmental entities' commitment and capacity to promote and coordinate prevention strategies

Outcome Statement 2: The commitment and capacity of local government to promote and coordinate primary prevention programs locally, regionally and statewide will be increased by 10% in 5 years.	
Who will change?	Local governments
What will change?	Commitment and capacity to promote prevention programs, strategies and activities, as well as the number of policies implemented and the number of prevention trainings conducted/sponsored.
How much change is realistic?	10% increase
By when will change occur?	Five years
How will change be measured?	A survey of organizations working on domestic violence will be conducted bi-annually to document their perception of change in local governments' commitment and capacity to promote and coordinate prevention strategies over time.

Strategic Direction 3:

Support the dissemination of primary prevention strategies for youth and young adults in non-school based settings.

Goal Statement 3: Domestic violence programs will increase the number of primary prevention strategies implemented in non-school based, youth and young adult serving organizations, by 20% in 5 years. Particular attention will be paid to underserved youth and young adults.	
Who will change?	Organizations working on domestic violence
What will change?	The number of primary prevention strategies in non-school based settings
How much change is realistic?	20%
By when will change occur?	Five years
How will change be measured?	A survey of domestic violence programs will be conducted bi-annually to document prevention programs implemented in non-school based, youth and young adult settings.

Rationale 3: There is considerable evidence that suggests that school-based prevention programs can be effective in changing Knowledge, Attitudes, Beliefs, and Behavior (KABB). What of youth and young adults that are not exposed to prevention strategies in school based settings? Prevention Consortium members wish to explore ways in which domestic violence organizations can partner with agencies and systems that serve "at-risk" youth such as youth on probation or youth determined by family court to be Persons in Need of Supervision (PINS); youth in delinquency settings; and youth on parole. Several domestic violence programs in New York State have experience providing prevention programming to this selected population and can be called upon to develop this strategy. (Wolfe DA, Wekerle C, Scott K, Straatman A, Grasley C, Reitzel-Jaffe D., 2003).

According the *Youth Violence: A Report to the Surgeon General* (2001), effective strategies for youth primary prevention is: 1) skills training, 2) behavior monitoring and reinforcement, 3) behavioral techniques for classroom management, 4) building school capacity, 5) continuous progress programs, 6) cooperative learning and 7) positive youth development programs. Effective primary prevention programs involve families, peers, schools, and communities to achieve multiple outcomes. As such non-traditional (i.e., non-school-based) settings need to be more a part of the mix.

Non-school based setting include organizations that serve youth and young adults such as Gay/Straight Alliances or GSA's; delinquency settings or residential facilities for youth; neighborhood and community centers; faith based communities and organizations; Planned Parenthood and peri-natal

organizations; as well as workplace settings. While Prevention Consortium members are particularly interested in meeting needs for youth who are considered "at risk" and who are not actually in school settings, they are also aware that young people who are not considered "at risk" may simply not have exposure to prevention messaging in schools. There is great potential and utility in engaging in extensive outreach efforts to non-school based partners.

Outcome Statement 1: Domestic violence programs will cultivate 20% more non- school based primary prevention partners focusing on youth and young adults by the end of 5 years.	
Who will change?	Organizations working on domestic violence
What will change?	Non-school based primary prevention partners focusing on youth and young adults
How much change is realistic?	20%
By when will change occur?	By the end of 5 years
How will change be measured?	A survey of domestic violence programs will be conducted bi-annually to document their non-school based partnerships that result in primary prevention activities.

Outcome Statement 2: Domestic violence programs will increase the number of and diversity of community-based partners committed to primary prevention of domestic violence by 20% in 5 years.	
Who will change?	Civic, municipal, local, neighborhood and volunteer organizations
What will change?	Commitment to primary prevention
How much change is realistic?	20%
By when will change occur?	Five years
How will change be measured?	A survey of domestic violence programs will be conducted bi-annually to document increase in the number and diversity of community-based partnerships in primary prevention over time.

Outcome Statement 3: Domestic violence programs will increase the number of and diversity of community-based partners that collaborate on drafting and implementing workplace violence policies that promote healthy, respectful relationships by 20% in 5 years.	
Who will change?	Civic, municipal, local, neighborhood and volunteer organizations, as well as local businesses and workplace settings
What will change?	Commitment to primary prevention
How much change is realistic?	20%
By when will change occur?	Five years
How will change be measured?	A survey of domestic violence programs will be conducted bi-annually to document an increase in the number and diversity of community-based partnerships and resulting workplace policies implemented.

Strategic Direction 4:

Support the dissemination of primary prevention strategies for youth and young adults in school based settings.

Goal Statement 4: Increase the number of primary prevention strategies focusing on youth and young adults that are implemented by domestic violence programs in school based settings.	
Who will change?	Organizations working on domestic violence
What will change?	The number of primary prevention strategies in school based settings
How much change is realistic?	20%
By when will change occur?	Five years
How will change be measured?	A survey of domestic violence programs will be conducted bi-annually to document school based prevention programs focusing on youth and young adults.

Rationale 4: There is considerable evidence that schools are effective settings for activities aimed at preventing and reducing dating violence. The NYSCADV Prevention Model enhances traditional teen dating violence awareness programs and takes them one step further by growing and nurturing students to become change agents themselves. Organizations working on domestic violence can be instrumental in helping schools make the paradigm shift from conducting programs that include one-time sessions to implementing ongoing, comprehensive and youth led prevention activities.

Outcome Statement 1: Domestic violence programs will cultivate 20% more school based primary prevention partners focusing on youth and young adults by the end of 5 years.	
Who will change?	Organizations working on domestic violence
What will change?	School based youth and young adult primary prevention partners
How much change is realistic?	20%
By when will change occur?	Five years
How will change be measured?	A survey of domestic violence programs will be conducted bi-annually to document their school-based partnerships that result in primary prevention activities.

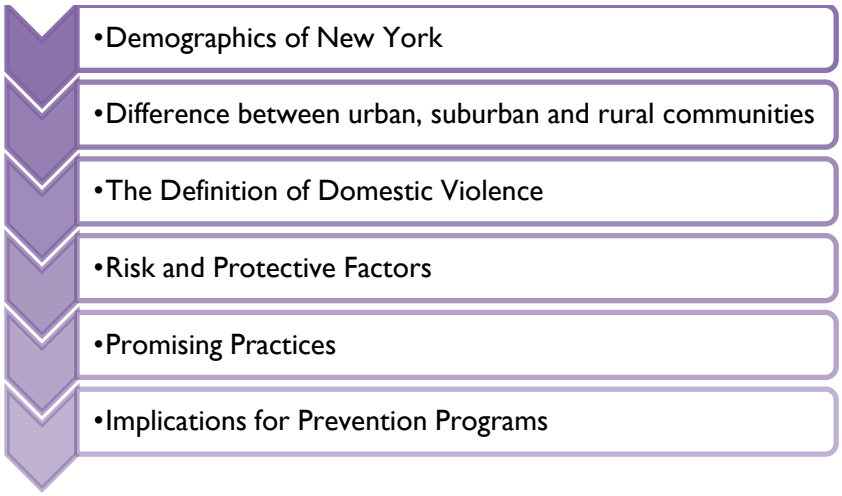
Outcome Statement 2: Domestic violence programs will increase the number of and diversity of school-based partners committed to primary prevention of intimate partner violence and dating violence by 20% in 5 years.	
Who will change?	Organizations working on domestic violence
What will change?	Commitment to primary prevention
How much change is realistic?	20%
By when will change occur?	Five years
How will change be measured?	A survey of domestic violence programs will be conducted annually to document their perception of change in the number and diversity of school-based partners

EVIDENCE BASED STRATEGIES, STATE & COMMUNITY CONTEXT, CAPACITY

The Consortium used *Getting To Outcomes: Methods and Tools for Planning, Evaluation, and Accountability (GTO)* (Wandersman, Imm, Chinman, & Kaftarian, 2000), which is a 10-step[7], logically organized process for planning, implementing, evaluating and continuously improving programs and community initiatives as a framework for creating this plan. GTO is designed to help programs and initiatives do exactly what it says: *get to the desired outcomes.*

Needs/Resources Assessment and Prevention System Capacity

In response to the GTO accountability question no. 1, NYSCADV conducted a state-level assessment utilizing the experience and knowledge of Consortium members in key informant interviews. Key informants were given a fact sheet with demographics of New York and magnitude and prevalence data. Key informants were asked to provide insights about:



[7] The 10 accountability questions of GTO are as follows:

1. What are the underlying needs and resources that must be addressed? (NEEDS/RESOURCES)
2. What are the goals, target population, and objectives (i.e. desired outcomes) that will address the needs and change the underlying conditions (GOALS)?
3. Which science (evidence)-based models and best practice programs can be used to reach your goals (BEST PRACTICE)?
4. What actions need to be taken so that the selected program "fits" the community context (FIT)?
5. What organizational capacities are needed to implement the prevention program (CAPACITIES)?
6. What is the plan for this program (PLAN)?
7. How will the quality of the implementation be assessed (IMPLEMENTATION)?
8. How well did the program work (OUTCOMES)?
9. How will continuous quality improvement strategies be incorporated (CQI)?
10. If the program is successful, how will it be sustained (SUSTAIN)?

(Wandersman, Imm, Chinman, & Kaftarian, 2000)

Key informants were also asked to provide insights about our states' prevention system capacity. The assessment included eight dimensions and sought to understand our committee members' perceptions of our states' capacity level at each dimension. To conduct the assessment, our planning team created a prevention system capacity assessment tool. The tool laid out the eight dimensions:

Each dimension was briefly explained and two questions were asked for each dimension:

1. How would we describe our state's "dimension name or phrase" today?
2. Would we say our "dimension name or phrase" gives us **low**, **medium** or **high** capacity?

The results were:

1. State System Profile → Low-Medium
2. Leadership → Medium-High
3. Strategic Planning → Medium
4. Information → Low
5. Community and Constituency Focus → Low-Medium
6. Human Resources → Medium
7. Systems Operations → Medium
8. Results/Outcomes → Medium

This assessment input was coupled with our needs assessment information to help inform step 2 of the GTO process - goals. Our goals are defined as four strategic directions for the NYS Intimate Partner Violence Prevention Plan. Two of these goals are focused on the **prevention system capacity** dimension – enhance coordination among the public sector entities of the NYS Intimate Partner Violence Prevention System and strengthen existing domestic violence programs towards promoting primary prevention of domestic violence.

GTO Step 3, 4, and 5

Consistent with steps 3, 4, and 5 of GTO, the Consortium conducted a number of prevention oriented activities to understand best practices, fit and capacity. The Consortium:

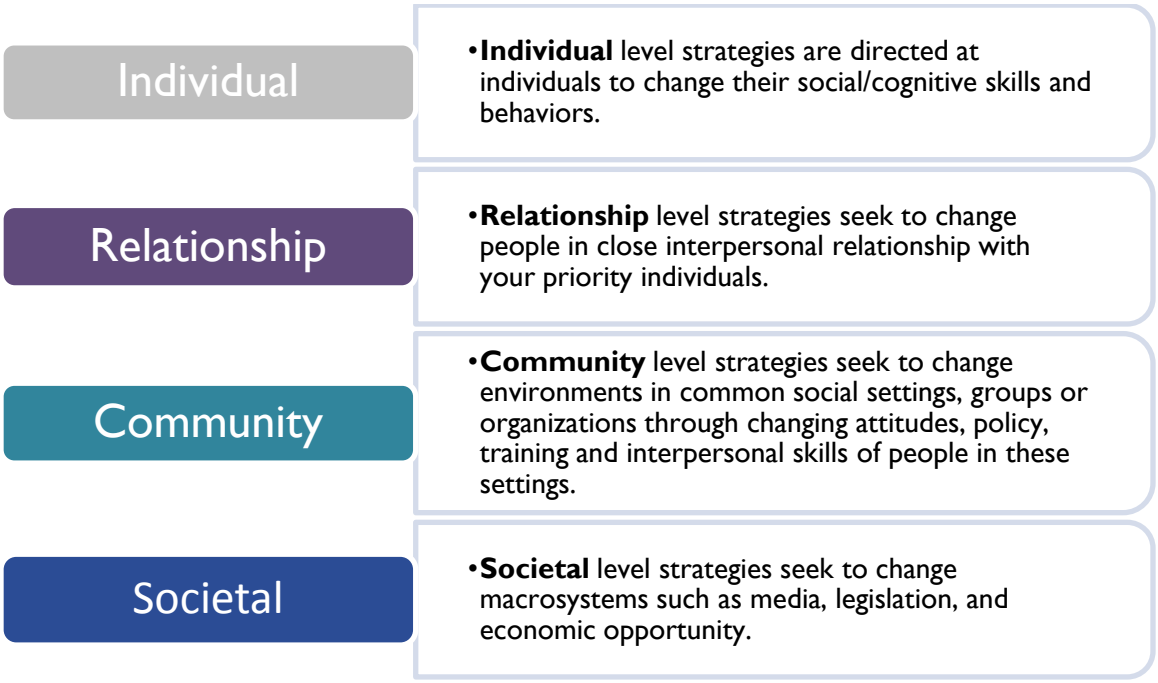
- Δ oriented themselves to the public health approach to primary prevention.
- Δ learned about the "NYSCADV Prevention Model."
- Δ explored promising practices for engaging youth.
- Δ explored promising practices for engaging adults.
- Δ discussed community organizing practices.

Public Health Approach to Primary Prevention

Consistent with the emphasis on the great work generated from public health model approaches, the Prevention Team adopted the primary prevention approach used by The CDC. The CDC which uses a public health perspective to categorize a continuum of prevention: primary, secondary and tertiary. Primary prevention approaches take place before domestic violence has occurred to prevent first time victimization or perpetration. Secondary prevention attempts to prevent violence from happening again and addresses the short-term consequences, while tertiary prevention focuses on long term issues dealt with through treatment of abusers and ongoing healing support for victims. Many secondary and all tertiary prevention efforts can be called intervention. Thus primary prevention does not replace intervention instead complements it. Communities must have safety and support for victims and accountability for abusers in place in addition to working on primary prevention.

Designing primary prevention efforts that recognize the interrelation between people and their environments has emerged as a critical step to effective change. Adopting another best practice, the Prevention Team employed the **Social Ecological Model**, which is a framework that is built on the multidimensional and complex aspects of people's lives and identifies that behaviors do not occur in a vacuum (CDC, n.d.). The four levels of the model – individual, relationship, community and society – are connected and reinforce each other, while representing separate, but complementary avenues through which to prevent domestic violence. Traditionally, efforts for prevention have naturally gravitated toward individual and relationship level activities. Identifying strategies and engaging at community and societal levels of change is more complex and takes dedication, creativity and time.

The Social Ecological Model



Critical elements for the primary prevention of domestic violence include directing efforts to the general population instead of working solely with victims, their children and abusers, and comprehensive approaches that address individual as well as community and system change in order to generate and reinforce new social norms. The Prevention Institute defines primary prevention as "taking action to build resilience and prevent problems before they occur" (Prevention Institute, 2008. Pg. 1). Primary prevention policies and programs help prevent violent behavior through strategies that eliminate the underlying causes and risk factors and strengthen protective factors.

In the article *What Works in Prevention: Principles of Effective Prevention Programs*, the authors used a review-of-reviews approach across four areas (substance abuse, risky sexual behavior, school failure, and juvenile delinquency and violence) to identify characteristics consistently associated with effective prevention programs (Nation, Crusto, Wandersman, Kumpfer, Seybolt, Morrissey-Kane, Davino, 2003). Local communities receiving DELTA funds are attempting to apply these elements to develop primary prevention programs in their evaluation process. The principles include:

1. Comprehensive
2. Varied Teaching Methods
3. Sufficient Dosage
4. Theory Driven
5. Positive Relationships
6. Appropriately Timed
7. Socio-Culturally Relevant
8. Outcome Evaluation
9. Well-Trained Staff
10. Process Evaluation
11. Accessibility

NYSCADV Prevention Model

The NYSCADV Prevention Model combines public health principles, domestic violence movement based social change theory and community organizing principles, and an analysis of the interconnectedness of oppressions – sexism, racism, heterosexism, classism, adultism, ableism, etc. – to frame the complexity of domestic violence and develop strategies to prevent it. Grounded in an analysis of domestic violence that is premised on sexism and oppression, exemplified by social constructs that prioritize categories of people, and results in the objectification of women and other oppressed groups, and unequal access to power and resources, the NYSCADV Prevention Model fosters creative strategies for community organizing and locally tailored initiatives while maintaining core principles about domestic violence in the social ecology.

Changing social norms is about changing the values that support perpetration rather than changing behaviors of at-risk victims. The NYSCADV Prevention Model promotes approaches that lead from awareness to action and values practices that are inclusive of the group that is being engaged, or exposed, to prevention messaging and activities. For instance, in a setting that is addressing the prevention of teen dating violence, NYSCADV's experience with prevention over the past fifteen years has shown that partnering with youth, cultivating their skills and capacity and engaging them as partners and peers in the programming is a critical factor to the success of the program. Broad based and inclusive collaboration integrating public health and prevention principles, community organizing approaches and a strong commitment to ending oppression of all kinds and promoting social justice and equity is the foundation of the NYSCADV Prevention Model.

Promising Practices for Engaging Youth

Promising practices reviewed include Men of Strength (MOST) Clubs, Expect Respect, White Ribbon Campaign (Education and Action Kit), Mentors for Violence Prevention (MVP), Coaching Boys Into Men, Please Stand Up and various Paul Kivel curricula.

Promising Practices for Engaging Adults

Promising practices reviewed include Cornell University ILR Workplace Violence Initiative, "Jump Start" Events by Call to Men – Tony Porter, Men Can Stop Rape, Paul Kivel and Jackson Katz; and "Campaigns by White Ribbon Campaign and Founding Fathers.

Community Organizing Practices

Promising practices reviewed include the People's Institute, Transforming Communities and the Wellstone Institute. For GTO steps 4 & 5 the Consortium articulated the vision that prevention programs need to be:

- Δ Driven by context
- Δ Multi-faceted
- Δ Community specific
- Δ About capacity building models
- Δ About stakeholder buy-in
- Δ About shifting social norms

One Consortium member illustrated this vision with the following:

"So rather than try to deliver a statewide message, perhaps deliver a set of principles statewide."

The process of working through these activities for Steps 3, 4 and 5 led to the development of the selected population goal--Support the dissemination of primary prevention strategies for youth and young adults in non-school based settings and the universal population goal--Support the dissemination of primary prevention strategies for youth and young adults in school based settings.

PREVENTION PLAN

The purpose of this prevention plan is to identify best practices for the prevention of domestic violence in order to advance the prevention of domestic violence in New York State. The four major goals identified Strategic Directions for the Primary Prevention of Intimate Partner Violence in New York State provides a structure for implementing a range of activities that together create a comprehensive approach to preventing domestic violence in New York. No single prevention strategy can end domestic violence when implemented in isolation.

1. Strengthen the existing capacity of domestic violence programs to promote primary prevention of domestic violence.
2. Promote coordination among the public sector entities within the Intimate Partner Violence Prevention System in New York.
3. Support the dissemination of primary prevention strategies for youth and young adults in non-school based settings**.**
4. Support the dissemination of primary prevention strategies for youth and young adults in school based settings.

Prevention System Capacity Goals and Outcomes

Strategic Direction 1: Strengthen the existing capacity of domestic violence programs to promote primary prevention of domestic violence.

Goal Statement 1: Strengthen existing capacity of domestic violence programs to conduct primary prevention strategies.

Outcome Statement 1: Domestic violence programs will conduct 20% more primary prevention activities by the end of 5 years.

Promising Strategies:

Δ Make primary prevention resources and promising practices widely available to domestic violence practitioners through an online toolkit

Δ Create and offer basic and advanced workshops and trainings on primary prevention concepts and practices to create new primary prevention programs and enhance existing programs.

Δ Foster a collaborative network of domestic violence organizations that are interested in starting or enhancing primary prevention work.

Δ Create a community of practice among domestic violence programs interested in furthering a statewide agenda that advances primary prevention knowledge and skills.

Δ Refine primary prevention definitions and messages based on knowledge of risk and protective factors in New York, and disseminate this to domestic violence programs.

Outcome Statement 2: Domestic violence programs increase their capacity to conduct primary prevention activities by 30% by the end of 5 years.

Promising Strategies:

- Explore appropriate models and approaches to community organizing and make them available to New York's diverse communities.
- Create and offer basic and advanced training programs on community organizing concepts and skills.
- Offer basic and advanced facilitative leadership and strategic planning trainings.
- Make primary prevention resources and promising practices widely available to domestic violence practitioners through an online toolkit.

Strategic Direction 2: Promote coordination among the public sector entities within New York's Intimate Partner Violence Prevention System.

Goal Statement 2: Enhance the coordination of public sector entities within the Intimate Partner Violence Prevention System in New York by 20% in 5 years.

Outcome Statement 1: The commitment and capacity of state entities to promote and coordinate primary prevention programs locally, regionally and statewide will be increased by 10% in 5 years.

Promising Strategies:

- Provide educational opportunities for legislators, state level policy makers, administrators and staff of state agencies on the importance of primary prevention of domestic violence and current successful strategies being implemented.
- Assist agency staff to incorporate primary prevention into selected existing programs.
- Recruit primary prevention experts who will provide technical support to agency staff for program development and evaluation.
- Provide technical support and resources to state agencies that request assistance with primary prevention programs, including policy development.
- Make primary prevention resources and promising practices widely available to domestic violence practitioners through an online toolkit. Have information regarding legislative and state level policy initiatives available.

Outcome Statement 2: The commitment and capacity of local government to promote and coordinate primary prevention programs locally, regionally and statewide will be increased by 10% in 5 years.

Promising Strategies:

- Δ Provide educational opportunities for county level policy makers and staff within local governments on the importance of primary prevention of domestic violence.
- Δ Assist agency staff to incorporate primary prevention into selected existing programs.
- Δ Recruit primary prevention experts who will provide technical support to agency staff for program development and evaluation.
- Δ Provide technical support and resources to local governments that request assistance with primary prevention programs, including policy development.
- Δ Provide support to domestic violence programs that are collaborating with local government to coordinate primary prevention programs.
- Δ Make primary prevention resources and promising practices widely available to domestic violence practitioners through an online toolkit. Have policy level prevention information available.

Selected Population Goal and Outcomes

Strategic Direction 3: Support the dissemination of primary prevention strategies for youth and young adults in non-school based settings.

Goal Statement 3: Domestic violence programs will increase the number of primary prevention strategies implemented in non-school based, youth and young adult serving settings, by 20% in 5 years. Particular attention will be paid to underserved youth and young adults.

Outcome Statement 1: Domestic violence programs will cultivate 20% more non-school based primary prevention partners focusing on youth and young adults by the end of 5 years.

Promising Strategies:

- Δ Explore models and approaches for community-based prevention strategies for youth and young adults.
- Δ Make primary prevention resources and promising practices widely available to domestic violence practitioners through an online toolkit. Have resources that nurture youth activism available, including those that encourage youth-created, youth led activities and messaging.
- Δ Create and offer basic and advanced training programs to youth and young adults on community organizing concepts and skills, including leadership training.

- Identify potential local and regional partners serving "at risk" youth.

- Identify opportunities to coordinate efforts with local and state agencies that interface with "at-risk" youth, such as probation and parole.

- Identify community and cyber-based young adult affinity groups, and explore ways to introduce primary prevention and community organizing concepts.

- Cultivate workplace settings and labor unions as partners in prevention, thereby reaching youth and young adults that may not be exposed to prevention messaging elsewhere.

Outcome Statement 2: Domestic violence programs will increase the number of and diversity of community-based partners committed to primary prevention of domestic violence by 20% in 5 years.

Promising Strategies:

- Promote the idea of primary prevention of domestic violence to local communities by collaborating with diverse local allies that serve youth and young adults (Service Clubs; YMCA/YWCA; Scouts; neighborhood associations, Gay-Straight Alliances, ethnic/minorities service agencies, i.e., programs that serve migrant farm workers, faith communities, family planning and prenatal organizations, to name a few.)

- Create and offer primary prevention training to new local collaborations.

- Engage new local partnerships in the New York domestic violence primary prevention network.

- Make primary prevention resources and promising practices widely available to domestic violence practitioners through an online toolkit. Have resources available that describe successful community partnerships.

Outcome Statement 3: Domestic violence programs will increase the number of and diversity of community-based partners that collaborate on drafting and implementing workplace violence policies that promote healthy, respectful

Promising Strategies:

- Promote the idea of primary prevention of domestic violence by collaborating with civic, municipal, local, neighborhood and volunteer organizations, as well as local businesses and other workplace settings.

- Connect partners with appropriate workplace violence policy samples and templates.

- Connect partners with appropriate training and technical assistance available to support the drafting and implementation of workplace violence policies.

- Make primary prevention resources and promising practices widely available to domestic violence practitioners through an online toolkit. Have workplace violence policies and primary prevention strategies appropriate for workplace settings available.

Universal Goal and Outcomes

Strategic Direction 4: Support the dissemination of primary prevention strategies for youth and young adults in school based settings.

Goal Statement 4: Increase the number of primary prevention strategies focusing on youth and young adult that are implemented by domestic violence programs in school-based settings.

Outcome Statement 1: Domestic violence programs will cultivate 20% more school based primary prevention partners focusing on youth and young adults by the end of 5 year

Promising Strategies:

Δ Make primary prevention resources and promising practices widely available to domestic violence practitioners through an online toolkit. Disseminate evidence-based primary prevention strategies developed by NYS DELTA Project participants.

Δ Compile and disseminate local DELTA project results pertaining to effective school-based strategies.

Outcome Statement 2: Domestic violence programs will increase the number of and diversity of school-based partners committed to primary prevention of intimate partner violence and dating violence by 20% in 5 years.

Promising Strategies:

Δ Outreach to NYS Department of Education regarding prioritizing school based IPV prevention strategies and policies.

Δ Compile and disseminate local DELTA project results pertaining to effective school based strategies to the NYS Department of Education, and other state level entities, to shift the paradigm for teen dating violence programming from awareness to action.

Δ Make primary prevention resources and promising practices widely available to domestic violence practitioners through an online toolkit. Disseminate evidence-based primary prevention strategies developed by NYS DELTA Project participant.

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