Intimate Partner Violence Prevention

Resource for Action

A Compilation of the Best Available Evidence

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

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The title of this document was changed in July 2023 to align with other Prevention Resources being developed by CDC's Injury Center. The document was previously cited as "Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices."

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Contents

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We dedicate this document to the memory of our co-author, Shalon M. Irving, who passed away during the development of this publication. We are grateful for the time we shared with Shalon working on this publication. "Dr. Shalon", as she was affectionately known, worked tirelessly to improve community health outcomes and brought joy to everyone who knew her. Her efforts to prevent violence, particularly among those at highest risk, is an important part of her legacy.

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Overview

This Prevention Resource presents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent intimate partner violence (IPV) and its consequences across the lifespan. These strategies include teaching safe and healthy relationship skills; engaging influential adults and peers; disrupting the developmental pathways toward IPV; creating protective environments; strengthening economic supports for families; and supporting survivors to increase safety and lessen harms. The strategies represented in this resource include those with a focus on preventing IPV, including teen dating violence (TDV), from happening in the first place or to prevent it from continuing, as well as approaches to lessen the immediate and long-term harms of partner violence. Commitment, cooperation, and leadership from numerous sectors, including public health, education, justice, health care, social services, business and labor, and government can bring about the successful implementation of this resource.

What is a Prevention Resource?

A Prevention Resource, formerly known as a technical package, is a compilation of a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome.[1] CDC's Prevention Resources for Action help communities and states prioritize prevention activities based on the best available evidence. This resource has three components. The first component is the ***strategy*** or the preventive direction or actions to achieve the goal of preventing IPV/TDV. The second component is the ***approach***. The approach includes the specific ways to advance the strategy. This can be accomplished through *programs, policies, and practices*. The ***evidence*** for each of the approaches in preventing IPV or TDV and/or associated risk factors is included as the third component. This resource is intended to guide and inform prevention decision-making in communities and states.

Preventing Intimate Partner Violence is a Priority

IPV is a serious preventable public health problem that affects millions of Americans and occurs across the lifespan.[2-4] It can start as soon as people start dating or having intimate relationships, often in adolescence. IPV that happens when individuals first begin dating, usually in their teen years, is often referred to as TDV. From here forward in this resource, we will use the term IPV broadly to refer to this type of violence as it occurs across the lifespan. However, when outcomes are specific to TDV, we will note that.

IPV (also commonly referred to as *domestic violence*) includes "physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)."[5] Some forms of IPV (e.g., aspects of sexual violence, psychological aggression, including coercive tactics, and stalking) can be perpetrated electronically through mobile devices and social media sites, as well as, in person. IPV happens in all types of intimate relationships, including heterosexual relationships and relationships among sexual minority populations. *Family violence* is another commonly used term in prevention efforts. While the term *domestic violence* encompasses the same behaviors and dynamics as IPV, the term *family violence* is broader and refers to a range of violence that can occur in families, including IPV, child abuse, and elder abuse by caregivers and others. This resource is focused on IPV across the lifespan, including partner violence among older adult populations. CDC has developed a separate Prevention Resource for the prevention of child abuse and neglect.[6]

IPV is highly prevalent. IPV affects millions of people in the United States each year. Data from the National Intimate Partner and Sexual Violence Survey (NISVS) indicate that nearly 1 in 4 adult women (23%) and approximately 1 in 7 men (14%) in the U.S. report having experienced severe physical violence (e.g., being kicked, beaten, choked, or burned on purpose, having a weapon used against them, etc.) from an intimate partner in their lifetime. Additionally, 16% of women and 7% of men have experienced contact sexual violence (this includes rape, being made to penetrate

someone else, sexual coercion, and/or unwanted sexual contact) from an intimate partner. Ten percent of women and 2% of men in the U.S. report having been stalked by an intimate partner, and nearly half of all women (47%) and men (47%) have experienced psychological aggression, such as humiliating or controlling behaviors.[3]

The burden of IPV is not shared equally across all groups; many racial/ethnic and sexual minority groups are disproportionately affected by IPV. Data from NISVS indicate that the lifetime prevalence of experiencing contact sexual violence, physical violence, or stalking by an intimate partner is 57% among multi-racial women, 48% among American Indian/Alaska Native women, 45% among non-Hispanic Black women, 37% among non-Hispanic White women, 34% among Hispanic women, and 18% among Asian-Pacific Islander women. The lifetime prevalence is 42% among multi-racial men, 41% among American Indian/Alaska Native men, 40% among non-Hispanic Black men, 30% among non-Hispanic White men, 30% among Hispanic men, and 14% among Asian-Pacific Islander men.[3] Additionally, the NISVS special report on victimization by sexual orientation demonstrates that some sexual minorities are also disproportionately affected by IPV victimization; 61% of bisexual women, 37% of bisexual men, 44% of lesbian women, 26% of gay men, 35% of heterosexual women, and 29% of heterosexual men experienced rape, physical violence, and/or stalking from an intimate partner in their lifetimes.[7] In regards to people living with disabilities, one study using a nationally representative sample found that 4.3% of people with physical health impairments and 6.5% of people with mental health impairments reported IPV victimization in the past year.[8] Studies also show that people with a disability have nearly double the lifetime risk of IPV victimization.[9]

IPV starts early in the lifespan. Data from NISVS demonstrate that IPV often begins in adolescence. An estimated 8.5 million women in the U.S. (7%) and over 4 million men (4%) reported experiencing physical violence, rape (or being made to penetrate someone else), or stalking from an intimate partner in their lifetime and indicated that they first experienced these or other forms of violence by that partner before the age of 18.[3] A nationally representative survey of U.S. high school students also indicates high levels of TDV. Findings from the 2015 Youth Risk Behavior Survey indicate that among students who reported dating, 10% had experienced physical dating violence and a similar percentage (11%) had experienced sexual dating violence in the past 12 months.[10] In an analysis of the 2013 survey where the authors examined students reporting physical and/or sexual dating violence, the findings indicate that among students who had dated in the past year, 21% of girls and 10% of boys reported either physical violence, sexual violence, or both forms of violence from a dating partner.[11] While the YRBS does not provide national data on the prevalence of stalking victimization among high school students, we know from NISVS that nearly 3.5 million women (3%) and 900,000 men (1%) in the U.S. report that they first experienced stalking victimization before age 18.[3] A study conducted in Kentucky suggests that nearly 17% of high school students in that state report stalking victimization, with most students indicating that they were most afraid of a former boyfriend or girlfriend as the stalker.[12] Research also indicates that IPV is most prevalent in adolescence and young adulthood and then begins to decline with age,[2] demonstrating the critical importance of early prevention efforts.

IPV is associated with several risk and protective factors. Research indicates a number of factors increase risk for perpetration and victimization of IPV. The risk and protective factors discussed here focus on risk for IPV perpetration, although many of the same risk factors are also relevant for victimization.[13-14] Factors that put individuals at risk for perpetrating IPV include (but are not limited to) demographic factors such as age (adolescence and young adulthood), low income, low educational attainment, and unemployment; childhood history factors such as exposure to violence between parents, experiencing poor parenting, and experiencing child abuse and neglect, including sexual violence. Other individual factors that put people at risk for perpetrating IPV include factors such as stress, anxiety, and antisocial personality traits; attitudinal risk factors, such as attitudes condoning violence in relationships and belief in strict social norms for men and women; and other behavioral risk factors such as prior perpetration and victimization of IPV or other forms of aggression, such as peer violence, a history of substance abuse, a history of delinquency, and hostile communication styles.[13-16]

Relationship level factors include hostility or conflict in the relationship, separation/ending of the relationship (e.g., break-ups, divorce/separation), aversive family communication and relationships, and having friends who perpetrate/experience IPV.[15-16] Although less studied than factors at other levels of the social ecology, community or societal level factors include poverty, low social capital, low collective efficacy in neighborhoods (e.g., low willingness of neighbors

to intervene when they see violence), and harmful social norms in societies (i.e., beliefs and expectations about the roles and behavior of men and women).[16-17]

Additionally, a few protective factors have been identified that are associated with lower chances of perpetrating or experiencing TDV. These include high empathy, good grades, high verbal IQ, a positive relationship with one's mother, and attachment to school.[15] Less is known about protective factors at the community and societal level, but research is emerging indicating that environmental factors such as lower alcohol outlet density[18] and community norms that are intolerant of IPV[19] may be protective against IPV. Although more research is needed, there is some evidence suggesting that increased economic opportunity and housing security may also be protective against IPV.[20-22]

IPV is connected to other forms of violence. Experience with many other forms of violence puts people at risk for perpetrating and experiencing IPV. Children who are exposed to IPV between their parents or caregivers are more likely to perpetrate or experience IPV, as are individuals who experience abuse and neglect as children.[13,15,23] Additionally, adolescents who engage in bullying or peer violence are more likely to perpetrate IPV.[15,24] Those who experience sexual violence and emotional abuse are more likely to be victims of physical IPV.[14] Research also suggests IPV may increase risk for suicide. Both boys and girls who experience TDV are at greater risk for suicidal ideation.[25-26] Women exposed to partner violence are nearly 5 times more likely to attempt suicide as women not exposed to partner violence.[27] Intimate partner problems, which includes IPV, were also found to be a precipitating factor for suicide among men in a review of violent death records from 7 U.S. states.[28] Research also shows that experience with IPV (either perpetration or victimization) puts people at higher risk for experiencing IPV in the future.[4,13-14]

The different forms of violence often share the same individual, relationship, community, and societal risk factors.[29] The interconnections between the different forms of violence suggests multiple opportunities for prevention.[30] Many of the strategies included in this resource include example programs and policies that have demonstrated impacts on other forms of violence as reflected in CDC's other Prevention Resources for child abuse and neglect, sexual violence, youth violence and suicide.[6,31-33] Recognizing and addressing the interconnections among the different forms of violence will help us better prevent all forms of violence.

The health and economic consequences of IPV are substantial. Approximately 41% of female IPV survivors and 14% of male IPV survivors experience some form of physical injury related to their experience of relationship violence.[2] IPV can also extend beyond physical injury and result in death. Data from U.S. crime reports suggest that 16% (about 1 in 6) of murder victims are killed by an intimate partner, and that over 40% of female homicide victims in the U.S. are killed by an intimate partner.[34] There are also many other adverse health outcomes associated with IPV, including a range of cardiovascular, gastrointestinal, reproductive, musculoskeletal, and nervous system conditions, many of which are chronic in nature.[35] Survivors of IPV also experience mental health consequences, such as depression and posttraumatic stress disorder (PTSD).[36] Population-based surveys suggest that 52% of women and 17% of men who have experienced contact sexual violence, physical violence or stalking by an intimate partner report symptoms of PTSD related to their experience of relationship violence.[3] IPV survivors are also at higher risk for engaging in health risk behaviors, such as smoking, binge drinking, and HIV risk behaviors.[37]

A substantial proportion of survivors also report other negative impacts as a result of IPV, and there is wide variation in the proportions of female and male survivors reporting these impacts. Population-based surveys indicate that among women and men in the U.S. who have experienced contact sexual violence, physical violence, or stalking by an intimate partner during their lifetimes, 73% of the women and 36% of the men report at least one measured negative impact related to these victimization experiences (e.g., fear, concern for safety, missing school or work, needing services).[3] Among the female IPV survivors, 62% reported feeling fearful, 57% reported being concerned for their safety, 25% missed at least one day of school or work from the IPV, 19% reported needing medical care, and 8% needed housing services. Among the male survivors, 18% reported feeling fearful, 17% reported being concerned for their safety, 14% missed at least one day of school or work from the IPV, 5% reported needing medical care, and 2% needed housing services.[3]

Although the personal consequences of IPV are considerable, there are also considerable societal costs associated with medical services for IPV-related injury and health consequences, mental health services, lost productivity from paid work, childcare, and household chores, and criminal justice and child welfare costs. The only currently available estimates of societal costs of IPV are from the mid-1990s, but suggest that the annual costs even 20 years ago were estimated at $5.8 billion based on medical and mental health services and lost productivity alone.[38]

IPV can be prevented. Primary prevention of IPV, including TDV, means preventing IPV before it begins. Primary prevention strategies are key to ending partner violence in adolescence and adulthood and protecting people from its effects. Partner violence in adolescence can be a pre-cursor or risk factor for partner violence in adulthood. Many strategies to prevent IPV therefore see adolescence as a critical developmental period for the prevention of partner violence in adulthood. It is also important to assist survivors and their children and protect them from future harm. Although there is less evidence of what works to prevent IPV compared to other areas of violence, such as youth violence or child maltreatment, a growing research base demonstrates that there are multiple strategies to prevent IPV from occurring in the first place and to lessen the harms for survivors.[39] Strategies are available that can benefit adolescents and adults regardless of their level of risk as well as individuals and environments at greatest risk. A comprehensive approach that simultaneously targets multiple risk and protective factors is critical to having a broad and sustained impact on IPV. Even though more research is needed (e.g., to strengthen the evidence addressing community and societal level factors), we cannot let the need for further research impede efforts to effectively prevent IPV within our communities.

A comprehensive approach targeting multiple risk and protective factors is critical to having a broad and sustained impact on IPV.

Assessing the Evidence

This Prevention Resource includes programs, practices, and policies with evidence of impact on victimization, perpetration, or risk factors for IPV. To be considered for inclusion in the resource, the program, practice, or policy selected had to meet at least one of these criteria: a) meta-analyses or systematic reviews showing impact on IPV victimization or perpetration; b) evidence from at least one rigorous (e.g., randomized controlled trial [RCT] or quasi-experimental design) evaluation study that found significant preventive effects on IPV victimization or perpetration; c) meta-analyses or systematic reviews showing impact on risk factors for IPV victimization or perpetration, or d) evidence from at least one rigorous (e.g., RCT or quasi-experimental design) evaluation study that found significant impacts on risk factors for IPV victimization or perpetration. Finally, consideration was also given to the likelihood of achieving beneficial effects on multiple forms of violence; no evidence of harmful effects on specific outcomes or with particular subgroups; and feasibility of implementation in a U.S. context if the program, policy, or practice has been evaluated in another country.

Within this resource, some approaches do not yet have research evidence demonstrating impact on rates of IPV victimization or perpetration but instead are supported by evidence indicating impacts on risk factors for IPV (e.g., child maltreatment, harsh parenting, attitudes accepting of violence, financial stress). In terms of the strength of the evidence, programs that have demonstrated effects on IPV outcomes (reductions in perpetration or victimization) provide a higher-level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of certain approaches on IPV outcomes, such as those described in the strategy to *Disrupt the Developmental Pathways to Violence*, and approaches at the outer levels of the social ecology, such as economic policy and interventions addressing community-level risk factors. Thus, approaches in this resource that have effects on risk factors reflect the developmental nature of the evidence base and the use of the best available evidence at a given time.

There is a wide range in the nature and quality of evidence among the programs, policies, or practices that fall within one approach or strategy. Not all programs, policies, or practices that utilize the same approach (e.g., programs to teach young people skills to prevent dating violence) are equally effective – some have impact on dating violence behaviors while others do not, and even those that are effective may not work across all populations. Few programs have been designed for and tested with diverse populations (e.g., racial/ethnic, sexual minority, and incarcerated populations to name a few), so tailoring programs and more evaluation may also be necessary to address different population groups. The evidence-based programs, practices, or policies included in the resource are not intended to be a comprehensive list for each approach, but rather to serve as examples that have been shown to impact IPV victimization or perpetration or have beneficial effects on risk factors for IPV. In practice, the effectiveness of the programs, policies and practices identified in this resource will be strongly dependent on the quality of their implementation and the communities in which they are implemented. Implementation guidance to assist practitioners, organizations and communities will be developed separately.

Context and Cross-Cutting Themes

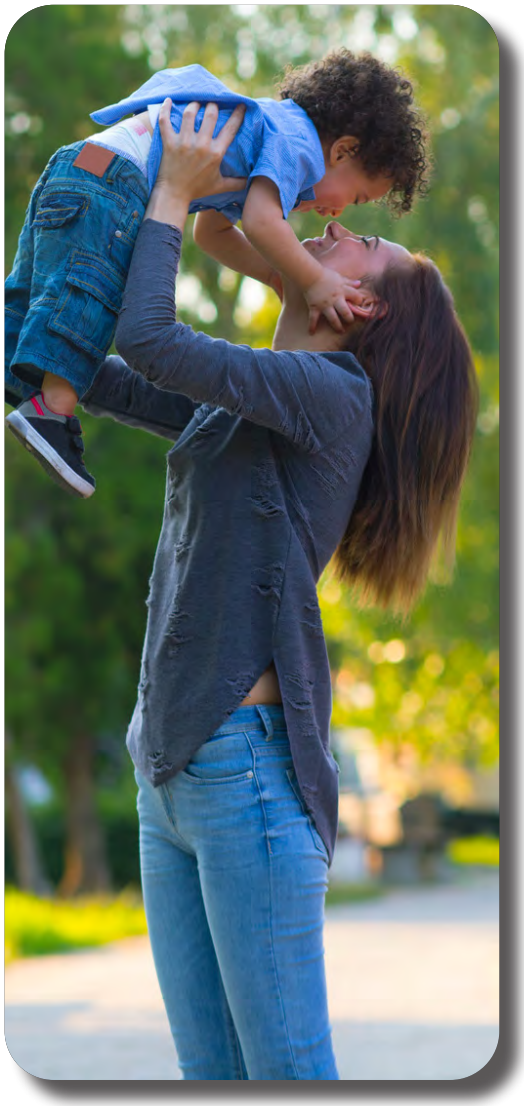
The strategies and approaches included in this Prevention Resource represent different levels of the social ecology, with efforts intended to impact individual behaviors and also the relationships, families, schools, and communities that influence risk and protective factors for IPV. The strategies and approaches are intended to work in combination and reinforce each other to prevent IPV (see box below). While individual skills are important and research has demonstrated preventive effects in reducing IPV, approaches addressing peer, family, school and other environments as well as societal factors are equally important for a comprehensive approach that can have the greatest public health impact.

Preventing IPV

Strategy	Approach
Teach safe and healthy relationship skills	• Social-emotional learning programs for youth • Healthy relationship programs for couples
Engage influential adults and peers	• Men and boys as allies in prevention • Bystander empowerment and education • Family-based programs
Disrupt the developmental pathways toward partner violence	• Early childhood home visitation • Preschool enrichment with family engagement • Parenting skill and family relationship programs • Treatment for at-risk children, youth and families
Create protective environments	• Improve school climate and safety • Improve organizational policies and workplace climate • Modify the physical and social environments of neighborhoods
Strengthen economic supports for families	• Strengthen household financial security • Strengthen work-family supports
Support survivors to increase safety and lessen harms	• Victim-centered services • Housing programs • First responder and civil legal protections • Patient-centered approaches • Treatment and support for survivors of IPV, including TDV

While each of the strategies and approaches in the resource has a particular focus, several important themes are cross-cutting and are addressed by multiple strategies. One of these is an emphasis on creating safe, stable, nurturing relationships and environments in childhood and adolescence to prevent IPV across the lifespan. Approaches such as social-emotional learning, early childhood home visitation, preschool enrichment, parenting skill and family relationship programs, and efforts to create protective environments and lessen harms are intended to address exposures to violence, build skills, strengthen relationships, and create the context to prevent IPV across the lifespan. The strategies and approaches in this regard are intended to be complementary and have a potentially synergistic impact. Changing social norms is another aspect that cross-cuts many of the strategies in this resource. Social norms supportive of violence are demonstrated risk factors for IPV.[13-15] Social tolerance of violence is learned in childhood and reinforced in different peer, family, social, economic, and cultural contexts. Challenging these norms is a key aspect of *Teaching Safe and Healthy Relationship Skills*, *Engaging Influential Adults and Peers*, and *Creating Protective Environments* in schools, neighborhoods, workplaces, and the broader community.

The strategies and approaches included in this resource represent current best practices in the primary prevention of IPV and supporting survivors with the after effects of IPV. This resource does not include approaches to prevent recidivism or treatment for offenders. *Batterer Intervention Programs (BIPs)* are widely used in communities and within the justice system, but the research findings on their effectiveness are mixed,[40-41] and conclusions of reviews have differed based on the level of rigor required for study inclusion, study methodology, and on the outcome used to determine effectiveness (police records vs. victim reports).[40] Due to the lack of clear evidence regarding the effectiveness of these programs in preventing further IPV,[40-42] *BIPs* are not included in this resource.



The example programs, policies, and practices in the resource have been implemented within particular contexts. Each community and organization working on IPV prevention across the nation brings its own social and cultural context to bear on the selection of strategies and approaches that are most relevant to its populations and settings. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches included here that are best suited to their context.

This resource includes strategies where public health agencies are well positioned to bring leadership and support to implementation efforts. It also includes strategies where public health can serve as an important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business or labor (e.g., workplace policies) is critical to implement a particular policy or program. The role of various sectors in the implementation of a strategy or approach in preventing IPV is described further in the section on *Sector Involvement*.

In the sections that follow, the strategies and approaches with the best available evidence for preventing IPV are described.

Teach Safe and Healthy Relationship Skills

Rationale

Fostering expectations for healthy relationships and teaching healthy relationship skills are critical to a primary prevention approach to the problem of IPV. The evidence suggests that acceptance of partner violence, poor emotional regulation and conflict management, and poor communication skills put individuals at risk for both perpetration and victimization of IPV.[15,43-44] Therefore, promoting expectations for healthy, non-violent relationships and building skills in these areas can reduce risk for perpetration and victimization of IPV. Previous research shows that strengthening social-emotional, conflict management, and communication skills can also reduce substance abuse, sexual risk behaviors, sexual violence, delinquency, bullying and other forms of peer violence.[31-32,45]

Approaches

There are a number of approaches that teach skills and promote expectations for healthy, non-violent relationships, including those that work with youth and with couples.

Social-emotional learning programs for youth promote expectations for mutually respectful, caring, non-violent relationships among young people and work with youth to help them develop social-emotional skills such as empathy, respect, and healthy communication and conflict resolution skills. Successful programs not only teach skills for safe and healthy relationships but also offer multiple opportunities to practice and reinforce these skills. Although typically implemented with adolescent populations in school-based settings, these approaches and skills may also be useful with young adults.

Healthy relationship programs for couples focus on improving relationship dynamics and individual well-being by improving communication, conflict management, and emotional regulation skills. Some of these programs work with couples who are engaged or just entering committed relationships to increase relationship quality, relationship satisfaction and relationship skills, while others work with couples trying to address a problem, such as substance use. Couples-based approaches have historically been controversial in the field of IPV *intervention*, and most agree that treatment programs for couples where severe violence and fear are already occurring are not safe for survivors.[46] For other couples, there is some evidence that relationship programs that focus on improving these relationship skills can demonstrate effectiveness in reducing the likelihood of IPV perpetration in the future.

Potential Outcomes

- Increases in the use of healthy relationship skills
- Reductions in perpetration of physical, sexual and emotional IPV and stalking
- Reductions in victimization of physical, sexual and emotional IPV and stalking
- Reductions in perpetration of peer violence, including bullying
- Reductions in high-risk sexual behaviors
- Reductions in attitudes that accept violence in relationships
- Increases in relationship satisfaction and well-being
- Reductions in substance abuse
- Reductions in weapon-carrying

Evidence

The current evidence suggests that both social-emotional programs for youth and relationship skills programs for adult couples can prevent IPV perpetration and victimization.

Social-emotional learning programs for youth. One program with evidence of effectiveness is *Safe Dates*, which is a school-based program focused on the promotion of healthy relationships and the prevention of TDV.[47] Originally developed for 8th and 9th graders, the program offers opportunities for students to learn and practice skills related to conflict resolution, positive communication, and managing anger. The program includes 10 classroom sessions, which provide many opportunities for role play and skill practice, a play presented to the entire school, and a poster contest. *Safe Dates* was evaluated in a randomized controlled trial and found to reduce both perpetration and victimization of physical and sexual dating violence, and results were sustained at four-year follow-up, into late-adolescence. Students exposed to the program reported between 56% and 92% less perpetration and victimization, respectively, at four-year follow-up when compared to control students, and program effects were consistent across sex, race, and baseline experience with TDV.[47] Students exposed to *Safe Dates* also reported a 12% reduction in peer violence victimization and a 31% reduction in weapon carrying at one-year follow-up compared to controls, demonstrating its effects on other violence outcomes associated with TDV.[48]

Another example is *"The Fourth R: Strategies for Healthy Teen Relationships."* The program is named *"The Fourth R"* to indicate that teaching youth about "relationships" is as important as teaching them the three R's of "reading, writing and arithmetic." This 21-session manualized curriculum focuses on 1) personal safety and injury prevention; 2) healthy growth and sexuality, and 3) substance abuse. The program offers multiple opportunities to practice and rehearse skills. *The Fourth R* was evaluated in a randomized controlled trial, and significant program effects were found among boys: boys in the intervention were almost three times less likely to report perpetration than boys in the control condition 2.5 years after baseline. However, there was no significant intervention effect on girls' perpetration.[49]

Expect Respect Support Groups (ERSG) are a socio-emotional learning approach for students at higher risk of TDV. *ERSG* is designed for teens who are in an abusive relationship or who have experienced any form of violence or abuse. Weekly support groups are led by trained facilitators. The 24-session curriculum focuses on developing communication skills, choosing equality and respect, recognizing abuse, learning skills for healthy relationships and becoming active proponents for safe and healthy relationships. Ball et al.[50] found that teens who completed the *ERSG* reported an increase in relationship skills and a decrease in TDV victimization and perpetration from pre to post-test. In a recent controlled evaluation of *ERSG* using an accelerated longitudinal design, the number of *ERSG* sessions attended related to significant incremental declines for boys on multiple outcomes, including perpetration and victimization of psychological TDV and sexual TDV, physical TDV victimization, and reactive and proactive aggression.[51] Girls who participated in *ERSG* demonstrated significant reductions in reactive and proactive aggression compared to treatment as usual control participants, but did not differ from controls on the TDV outcomes. It appears that *ERSG* has beneficial effects for both boys and girls in regard to reactive and proactive aggression, but is most effective for at-risk boys in regards to TDV perpetration and victimization.

Healthy relationship programs for couples. Programs that work with couples to build and strengthen relationship skills, including communication and conflict management skills, show evidence for preventing later IPV. One example is the *Pre-marital Relationship Enhancement Program (PREP)*, which is a five session intervention for couples planning to marry that focuses on teaching couples skills, techniques, and principles designed to enhance positive relationship functioning and promote effective management of negative affect with the goal of maintaining high relationship functioning and preventing problems from occurring in the relationship. This program has been empirically tested with many populations (e.g., community-based, active duty military, incarcerated populations) and in various delivery formats (group delivery, computer-delivered). In the original randomized controlled trial of *PREP*, at five-year follow-up couples who completed all or most of the *PREP* intervention had significantly lower levels of physical relationship violence than couples in the control group. The intervention group also had significantly higher levels of positive communication skills and lower levels of negative communication skills than the control group.[52] In a more recent RCT of *ePREP*, the computerized version of the *PREP* program, married couples receiving the intervention demonstrated significant reductions in reports of physical aggression and psychological aggression compared to individuals in a placebo-intervention control group at the 10-month follow-up.[53]

Another example of a couples-based program is *Behavioral Couples Therapy*, or *BCT*, which is an individually-based substance abuse treatment program for substance-abusing individuals and their partners. The therapy consists of a combination of 12-20 weekly couple-based sessions. The program works with the couple on conflict management and other relationship skills as part of the substance abuse treatment.[54] A substantive and methodological review of 23 studies (mostly quasi-experimental studies employing a demographically matched, non-alcoholic comparison group) found that *BCT* is associated with significant reductions in perpetration of IPV among couples participating in treatment groups.[54] The effects of *BCT* have been found for both male and female substance users and their partners, and these effects are particularly pronounced for individuals who successfully stopped drinking (remitted alcoholics).[54-57] Thus, the intervention appears most effective at reducing IPV among those for whom it is effective in preventing further substance use.[55-56]

Programs that work with couples to build and strengthen relationship skills, including communication and conflict management skills, show evidence for preventing later IPV.

Engage Influential Adults and Peers

Rationale

Programs that seek to engage influential adults and peers in promoting positive relationship expectations and condemning violent and unhealthy relationship behaviors among adolescents and young adults are critical to the prevention of IPV. Trusted adults and peers are important influencers of what adolescents and young adults think and expect and how they behave. Beliefs and attitudes about the acceptability of violence and equality between women and men are predictive of IPV perpetration.[15,58] Engaging adults and peers to promote social norms that support healthy relationship behaviors has great potential to change social contexts so that everyone knows that IPV is not acceptable and will not be tolerated, and people feel more willing and able to intervene when they see IPV.[59] These types of social contexts can discourage potential perpetrators from thinking that violence will be seen as acceptable and increase their perception of the risk that there may be social consequences to such behavior. These types of social contexts may also increase positive bystander behaviors, which can directly interrupt violence as well as enforce norms unaccepting of violence.[59]

Approaches

There are a number of approaches that seek to influence the social context within which partner violence occurs by engaging influential adults and peers.

Men and boys as allies in prevention. These approaches target men and boys and encourage them to be part of efforts to prevent IPV, including TDV. These approaches not only encourage men and boys to support actual and potential victims by intervening and speaking out, but also teach skills and promote social norms that reduce their own risk for future perpetration. These approaches often target men in peer groups, such as athletic teams and fraternities.

Bystander empowerment and education. These types of approaches attempt to promote social norms that are protective against violence and empower and encourage people to intervene to prevent violence when they see it. Participants in bystander empowerment and education programs learn specific strategies on how to intervene in situations that involve IPV. Types of bystanders targeted for intervention include: informal helpers (e.g., friends and roommates), popular opinion leaders (e.g., student government) or larger social groups (e.g., men on college campuses).

Family-based programs seek to involve parents and other caregivers in prevention of TDV. Family-based programs operate on the premise that the family is central to the development of norms and values, and therefore amenable to interventions that promote acceptable behavior. These approaches are designed to improve parental awareness and knowledge about TDV, change parental attitudes about the acceptability of TDV, improve parent communication skills around TDV and skills for helping their teens resolve relationship conflicts, and to improve their rule setting and monitoring skills.

Potential Outcomes

- Increase in self-efficacy and intentions to engage in active bystander behavior
- Reductions in perpetration of TDV and IPV
- Reductions in victimization of TDV and IPV
- Reductions in peer norms supportive of TDV and IPV
- Increase in parental/caregiver efficacy in resolving teen relationship conflicts and engaging in rule setting
- Reductions in acceptance of dating abuse among adolescents

Evidence

There is growing evidence that engaging men and boys, bystander approaches, and family-based programs can prevent IPV.

Men and boys as allies in prevention. Several programs have been developed and implemented that focus on engaging men and boys as allies in the prevention of IPV. One such program with rigorous evaluation evidence is *Coaching Boys into Men (CBIM)*, an eleven session coach-led intervention with male high school athletes in grades 9–12. *CBIM* provides coaches with training tools to model and promote respectful, non-violent, healthy relationships with their male athletes, and sessions are conducted during regularly scheduled team practices throughout the sports season. *CBIM* was evaluated in a randomized controlled trial and was found to significantly reduce perpetration of TDV at the 12-month follow-up assessment (including physical, sexual, and emotional aggression), as well as significantly reduce engagement in negative bystander behaviors (such as laughing or encouraging abusive behaviors).[60]

Bystander empowerment and education. Research focused on engaging bystanders has shown that efforts to increase bystander efficacy are beneficial in alcohol and drug use reduction and other health behaviors. More recently, these approaches have been applied to bullying, dating violence, and sexual assault. One example is *Bringing in the Bystander*. This program teaches college student participants about how relationship violence and sexual violence occur along a continuum from less aggressive to more severe behaviors, and teaches participants how to safely intervene, offering opportunities to practice these skills and create plans for how they will intervene to prevent violence as a bystander. Participants in the program demonstrated increased self-reports of likelihood to intervene and confidence in ability to intervene.[61-62] In one recent study, higher levels of engaging in bystander behaviors were reported by program participants at the one-year follow-up, when the situation involved helping friends (but effects were not found for situations involving strangers).[63] Higher intentions to intervene have been shown to be a protective factor for TDV, with one study finding these intentions to be associated with a 40% lower likelihood of perpetrating TDV.[58]

Another example of a bystander program is *Green Dot*. This program educates and empowers participants to engage in both reactive and proactive responses to interpersonal violence, such as dating or sexual violence, to reduce likelihood of assault. Bystander training is conducted in groups by trained facilitators in four to six hour training sessions. An evaluation of *Green Dot* implemented with college students found that after three years of implementation, the intervention campus had a 9% lower rate of overall violence victimization, 19% lower rate of sexual harassment and stalking perpetration, and 11% lower rate of sexual harassment and stalking victimization when compared with two non-intervention college campuses.[64] Male students on *Green Dot* campuses reported lower rates of perpetration of overall violence and lower rates of psychological dating violence relative to control campuses.

Female students on *Green Dot* campuses reported significantly less sexual assault resulting from inability to resist due to drugs or alcohol than female students on control campuses. There were no significant program effects for physical dating violence for male or female students.[64] An evaluation of the program across a four-year study period found similar results.[65] A randomized controlled trial of the program with high school students found significant reductions in dating violence perpetration and victimization after three years of program implementation, as well as reductions in other related violence outcomes such as sexual violence (including sexual harassment) and stalking.[66]

Family-based programs. Family-based programs have been successful in reducing teen risk behavior, such as high-risk sexual behavior,[67] and may hold promise for prevention of TDV. One example is the *Families for Safe Dates (FSD)* program. *FSD* consists of six booklets delivered to families (five of which are designed with interactive activities that caregivers and teens complete together). Each booklet targets change in constructs associated with TDV, including teen conflict resolution skills, teen's acceptance of dating abuse, and caregiver knowledge about dating and efficacy to influence TDV behavior. A health educator follows up with the caregiver two weeks after each booklet is mailed to gauge progress in completing activities, encourage participation, and answer questions. *FSD* was evaluated in a randomized controlled trial and found to motivate and facilitate parent/caregiver involvement in teen dating abuse prevention activities, increase caregiver self-efficacy for talking about dating abuse, and decrease negative communication with teens. At the 3-month follow-up, teens in the intervention group reported decreased acceptance of dating abuse, which is a risk factor for TDV perpetration and victimization, and significant reductions in reports of TDV victimization over time compared to no-treatment controls.[68]

Family-based programs have been successful in reducing teen risk behavior and may hold promise for prevention of TDV.

Disrupt the Developmental Pathways Toward Partner Violence

Rationale

Findings from several longitudinal studies indicate that many of the factors associated with perpetrating violence against intimate partners are evident well before adolescence.[69-71] These factors include poor behavioral control; social problem-solving deficits; early onset of drug and alcohol use; an arrest prior to the age of 13; and involvement with antisocial peers, crime and violence.[13,15,70-74] Findings from these studies also point to academic problems, exposure to chronic stress and adverse experiences such as child abuse and neglect, witnessing violence in the home and community, and parental substance abuse, depression, criminality, and incarceration.[69-71] Negative parenting behaviors (e.g., poor communication between family members, harsh and inconsistent discipline, poor parental monitoring and supervision, poor parent-child boundaries) and family environments that are unstable, stressful, and that lack structure are also risk factors for perpetration of TDV in adolescence and continued perpetration into adulthood.[15,73-75] Approaches that can disrupt these developmental risks and pathways have the potential to reduce IPV.

Approaches

There are a number of approaches for interrupting the developmental pathways contributing to partner violence, including those that address early childhood environments, parenting skills, and other supports to prevent future involvement in violence.

Early childhood home visitation programs provide information, caregiver support, and training about child health, development, and care to families in their homes. Home visiting programs may be delivered by nurses, professionals, or paraprofessionals.[76] Many programs are offered to low-income, first time mothers to help them establish healthy family environments.[76] The content and structure of programs vary depending on the model being utilized (e.g., some are highly manualized and others are more flexible in their delivery).[76] Some programs begin during pregnancy, while others begin after the birth of the child and may continue up through the child entering elementary school. Some programs also include components to address co-occurring risks such as IPV in the home.

Preschool enrichment with family engagement programs provide high-quality early education and support to economically disadvantaged families. These programs are designed to build a strong foundation for future learning and healthy development, and to lower the risks for future behavioral problems. Programs are generally available to children and families who meet basic qualifications, such as being residents in a high-poverty school area eligible for federal Title I funding, demonstrate need and agree to participate, or have incomes at or below the federal poverty level.[77] Parental involvement is an important component to these programs which often begin in infancy or toddlerhood and may continue into early or middle childhood.

Parenting skill and family relationship programs provide parents and caregivers with support and teach communication, problem-solving, positive parenting skills and behavior monitoring and management skills to reduce children's involvement in crime and violence and later risk of perpetrating IPV. Programs are typically designed for parents and families with children in a specific age range (e.g., preschool and elementary school, middle and/or high school) with the content tailored to the developmental stage of the child.[78-81] Programs may be self-directed or delivered to individual or groups of families. For families at high-risk for conflict and child behavior problems, tailored delivery to individual families yields greater benefits than group administration.[79,82-83]

Treatment for at-risk children, youth and families. These approaches are designed for children and youth with histories of child abuse and neglect, childhood aggression and conduct problems, and prior involvement in violence and crime. They are intended to mitigate the consequences of these exposures and prevent the continuation and escalation of violence into adulthood including abuse directed toward partners and one's own children. Referrals for therapeutic interventions and other supports may come from social services, the juvenile justice system, schools, or other community organizations working with children, youth, and families. Children of all ages may participate in these programs, although the specific age of children targeted depends on the specific program being implemented. Programs are often delivered by trained clinicians in the home or a clinic setting, and can be delivered to individual families or groups of families.

Potential Outcomes

- Reductions in child abuse and neglect
- Reductions in child welfare encounters
- Reductions in rates of out of home placement of children and youth
- Increases in parent-child engagement and interaction
- Reductions in harsh and ineffective discipline
- Increases in child health and development
- Reductions in rates of aggressive and social behavior problems in children and youth
- Improved social competency, pro-social behavior and interaction with peers
- Reductions in rates of deviant peer associations
- Reductions in rates of TDV and IPV
- Improvements in marital relationships
- Reductions in rates of involvement in crime, arrest and incarceration
- Higher educational attainment
- Higher rates of full time employment
- Higher socioeconomic status and economic self-sufficiency
- Reductions in rates of substance abuse
- Reductions in rates of depressive symptoms

Evidence

A large body of evidence highlights the importance of intervening early to prevent future involvement in violence, including future risk of perpetrating partner violence.

Early childhood home visitation. The evidence of effectiveness for home visiting programs is mixed, with some models showing few or no effects and others showing strong effects, potentially due to the varying content and delivery of these programs.[76] *Nurse Family Partnership (NFP)*, for instance, has been evaluated in multiple randomized controlled trials and found to be effective in reducing multiple risk factors for IPV. It is associated with a 48% relative reduction in child abuse and neglect, which is a risk factor for both victimization and perpetration of IPV.[84] The *NFP* program also reduced parental substance use, the use of welfare, and criminal behavior in women in the program compared to women in the comparison group.[84-85] At 25 and 50 months of age, children who had received nurse home visits had 45% fewer behavioral problems and parent coping problems as noted in the physician record.[86] By ages 15 and 19, participating youth had significantly fewer arrests, convictions, and probation violations and lower rates of substance use.[87-88] Although the effectiveness of home visits on IPV needs more study, in one *NFP* trial, nurse-visited women reported significantly less exposure to IPV in the previous six months at the four-year follow-up compared with those in the control group.[89]

Preschool enrichment with family engagement. These programs have documented positive impacts on the child's cognitive skills, school achievement, social skills, and conduct problems, and are effective in reducing child abuse and neglect and youth involvement in crime and violence, which are risk factors for perpetrating IPV. *Child Parent Centers (CPCs)* and *Early Head Start (EHS)* are two examples of effective programs. *CPCs* have been evaluated in multiple, long-term studies. By age 20, youth who participated in the preschool program (relative to youth in other early childhood programs) had significantly lower rates of juvenile arrest (16.9% vs 25.1%), violent arrests (9.0% vs 15.3%), and multiple arrests (9.5% vs 12.8%).[90] By age 24, those who participated in the program for four to six years (vs. preschool only) had significantly lower rates of violent arrests, violent convictions, and multiple incarcerations.[91] Across studies, participating youth relative to comparison groups experienced lower rates of substantiated reports of child abuse and neglect, out-of-home placements, grade retention, special education services, depression, and substance use, as well as higher rates of high school completion, attendance in four-year colleges, health insurance, and full-time employment in adulthood.[90-93]

Multiple evaluations of *EHS* also demonstrate significant program impacts on multiple risk factors for IPV among participants relative to comparison groups, including significantly fewer child welfare encounters, fewer reports of substantiated physical or sexual abuse,[94] better cognitive and language development; home environments that are more supportive of learning; less aggressive and other social behavior problems; and stronger parent-child engagement.[95-96]

Parenting skill and family relationship programs. *The Incredible Years®* and the *Parent Management Training Oregon Model (PMTO)* are two examples of effective parenting programs with impacts on risk and protective factors for perpetration of TDV and later partner violence. *The Incredible Years®* is designed for families with young children up to 12 years of age and can be implemented with additional components for teachers and children in school. A meta-analysis of program effects found significant decreases in child behavior problems, increases in prosocial behaviors, and improvements in parental monitoring, discipline, and mother-child interactions.[97] A randomized controlled trial of an enhanced version of the program also found beneficial effects for the non-target siblings, such as reduced antisocial behavior and improved peer-relations.[98-99]

PMTO is designed for parents of children ages 3 to 16. The program uses didactic instruction, modeling, role-playing, and home practice to teach parenting skills in encouragement, monitoring, limit setting, discipline, problem solving, and to foster parent-child engagement in activities. It is delivered in group and individual family formats in diverse settings (e.g., clinics, homes, schools, community centers, homeless shelters). *PMTO* is associated with reductions in coercive and harsh parenting of children, and increases in positive parenting practices and adaptive family functioning,[100-101] including among parents with a history of hard drug use (e.g., cocaine, heroin, LSD), physical aggression toward a former or current partner, and a prior arrest.[102] The program is also associated with reductions in child behavior problems and reductions in youth aggression, deviant peer associations, substance use, and rates of arrest.[103-104] Other benefits include increases in family socioeconomic status and greater rise out of poverty and improvements in the marital relationship.[101,105-106]

Treatment for at-risk children, youth and families. Several therapeutic programs have demonstrated impact on risk factors for later development of IPV, including reductions in violent behavior and substance use, and improvements in family functioning and positive parenting. A systematic review of therapeutic foster care approaches, such as *Multidimensional Treatment Foster Care (MTFC)*, demonstrate an approximate 72% reduction in violent crimes among participants.[107] *MTFC* provides short-term placements of children and youth with persistent and significant behavioral challenges with extensively trained foster parents, family therapy for biological parents, and behavioral and academic supports to youth. Multiple studies show the benefit of *MTFC* in reducing behavioral problems, attachment issues, and neurophysiological changes due to stress in preschool aged children; and reductions in violent crimes, incarceration, and substance abuse among adolescents.[108] For example, adolescent males who participated in *MTFC* were less likely to commit violent offenses than youth in service-as-usual group care. After controlling for age at placement, age at first arrest, official and self-reported prior offenses and time since baseline, 24% of group care youth had two or more criminal referrals for violent offenses in the two years following the baseline versus only 5% of MFTC youth.[109] At 12 and 18 months of follow-up, *MTFC* boys also had lower levels of self-reported tobacco, marijuana, and other drug use.[110]

Multisystemic Therapy (MST) is an intensive family and community-based treatment program for justice-involved youth that engages the youth's entire social network (e.g., friends, peers, family, teachers, school administrators, and members of the community). *MST* therapists meet with families and youth in their home, school, and community environments with the goal of strengthening family relationships, improving parenting skills, improving youths' academic achievement, and promoting prosocial activities and behavior. *MST* has been evaluated in numerous trials with samples of chronic and violent juveniles and is associated with significant long-term reductions in re-arrests (reduced by a median of 42%) and out-of-home placements (reduced by a median of 54%).[111] *MST* participants, relative to youth receiving individual therapy had fewer violent felony arrests approximately 22 years later (4.3% vs. 15.5%).[112] The siblings of these participants also had fewer arrests for any crime (43.3% vs. 72%) and felonies (15% vs. 34%) approximately 25 years later.[113] Other benefits include decreased rates of child maltreatment,[114] improvements in family functioning, parent-child interactions, and positive parenting practices, and reductions in youth's substance use and involvement with gangs.[111-112,115]

Several parenting and therapeutic programs have demonstrated impact on risk factors for IPV.

Create Protective Environments

Rationale

While many prevention strategies focus on individual and relationship-level factors that influence the likelihood of becoming a survivor or perpetrator of IPV, it is important to acknowledge the influence of community environments (i.e., schools, workplaces, and neighborhoods). Approaches that work to foster a broader social and physical environment that improves safety, social connections, and awareness of IPV can help create a climate that supports prevention of violence against intimate partners. These community-level approaches may encourage higher rates of disclosure of IPV, increase resources and support leveraged on behalf of IPV survivors, and promote social norms that are intolerant of IPV within the community, potentially increasing the likelihood that community members will intervene when they witness IPV.[19] Although evidence on community-level approaches for IPV prevention is just beginning to emerge, there is support for the role of neighborhood and community characteristics (e.g., neighborhood social control, social cohesion, collective efficacy, tangible help and support for IPV survivors, social norms) as important protective factors against perpetration of IPV.[13,29,116]

Approaches

Community-level approaches for creating protective environments against the perpetration of partner violence include efforts to:

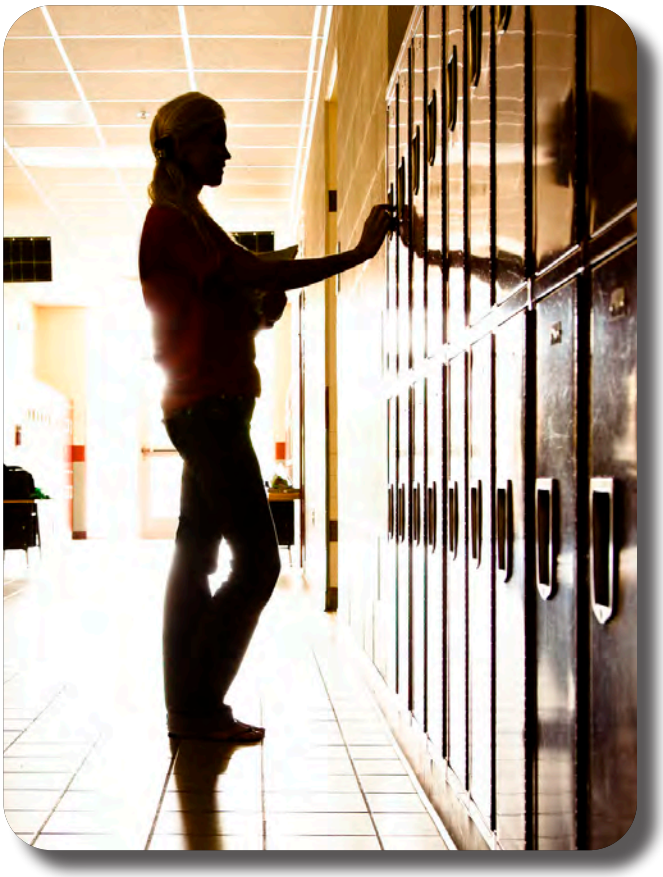
Improve school climate and safety. School environments offer a potentially influential context that can be changed or adapted to promote prevention of TDV. Approaches that increase support from school personnel and modify physical spaces in schools have potential to improve safety and raise awareness about dating violence and harassment. Creating a school environment that enhances safety and feelings of safety, promotes healthy relationships and respectful boundaries, and reduces tolerance for violence among students and school personnel can play an important role in reducing rates of TDV perpetration. While efforts have traditionally focused on middle and high school settings, there may be opportunities to adapt this type of approach to other school contexts, such as college and university settings.

Improve organizational policies and workplace climate. These types of approaches are designed to foster protective environments in the workplace through the creation of organizational policies and practices that promote safety and encourage help-seeking behavior. Workplace approaches can aid employees and managers in raising awareness about IPV, recognizing the potential for violence by an intimate partner of an employee occurring in the workplace, facilitate how incidents can be reported and handled, and demonstrate commitment to workplace safety (e.g., securing access points, visitor sign-in policies, crisis planning) while providing support and resources to employees experiencing IPV.[117] These approaches have potential to encourage disclosure of IPV, normalize help-seeking, and increase tangible aid and social support to employees, which has been shown to be a protective factor for IPV.[13] In addition, these approaches can facilitate positive changes in workplace climate, increase feelings of safety, and reduce perceived tolerance of violence towards intimate partners among managers and employees in the workplace.

Modify the physical and social environments of neighborhoods. These approaches address aspects of neighborhood settings that increase the risk for IPV, including alcohol outlet density, physical disorder and decay, and social disorder.[19,118-119] There are a number of mechanisms by which living in disadvantaged neighborhoods can place people at greater risk for IPV. These neighborhoods typically have higher rates of crime and violence. Exposure to neighborhood violence is a risk factor for IPV.[116,119] Additionally, the stress associated with living in disadvantaged neighborhoods and social norms that govern violence in these communities are also possible mechanisms for this increased risk.[119-120] Further, signs of neighborhood disorder may lead people, including potential perpetrators, to believe that consequences for IPV perpetration, such as police intervention, are less likely.[121] These community-level factors can be addressed by changing, enacting, or enforcing laws and regulations (e.g., alcohol-related policies); improving the economic stability of neighborhoods; and by changing the physical environment to improve social interaction, and strengthen community ties and social cohesion in order to promote residents' willingness to monitor and respond to problem behavior (e.g., collective efficacy). These types of approaches have potential for population-level impact on IPV/TDV outcomes, often at relatively low cost for implementation.

Potential Outcomes

- Reductions in rates of IPV and TDV perpetration
- Reductions in rates of IPV and TDV victimization
- Reductions in intimate partner homicides
- Reductions in rates of peer violence perpetration
- Reductions in sexual harassment perpetration
- Reductions in community violence
- Improvements in workplace climate towards reduction or prevention of IPV
- Increases in development of organizational policies and resource-seeking for IPV
- Increases in knowledge and awareness of IPV
- Reductions in excessive alcohol use at the community level
- Increases in neighborhood collective efficacy
- Increases in disclosure and reporting of IPV
- Increases in social support provided to survivors of IPV
- Reductions in violent crime



Evidence

Although still developing, there is some evidence supporting the use of community-level approaches to preventing partner violence.

Improve school climate and safety. The current evidence suggests that changing or adapting certain aspects of school settings to improve student safety has potential to reduce rates of TDV. For example, the building-level component of *Shifting Boundaries* is designed to improve safety in schools by increasing staff presence in "hot spots" (building areas designated by students and staff as unsafe); promoting awareness and reporting of TDV to school

personnel through a school-based poster campaign; and introducing temporary building-based restraining orders for students at risk for TDV. In a rigorous evaluation of the intervention in New York City middle schools, the building-level component was found to reduce sexual violence victimization in dating relationships by 50%.[122] No effects were found for sexual violence perpetration within teen dating relationships. However, the building level intervention was found to reduce the prevalence of sexual violence perpetration by peers (occurring outside of dating relationships) by 47% and sexual harassment perpetration by 34% compared to control schools that did not receive the classroom or building-level intervention.[122] The prevention effects on sexual violence perpetration by peers and sexual harassment perpetration are important because peer violence is an empirically established risk factor for later TDV perpetration.[15] This study was conducted in middle schools, so it is possible that it is too early developmentally to see effects on TDV perpetration. The fact that this intervention had an impact on risk factors for TDV perpetration, however, is promising.

Improve organizational polices and workplace climate. Similar to school settings, the workplace also represents an important context where safety and awareness around IPV could be addressed. For example, *IPV and the Workplace Training* is one intervention with evidence for significantly improving workplace climate towards IPV in county government organizations randomly assigned to receive the training, compared to a delayed control group.[123] The number of supervisors providing information to employees on a state law that provides protected work leave to IPV survivors significantly increased after receiving the training. Organizations in the intervention group demonstrated more public postings about the state leave law for IPV survivors and were more likely to develop IPV policies and seek additional IPV resources for employees than organizations in the delayed control group. While impact on IPV outcomes has not yet been tested, these findings may translate into increases within the workplace of tangible help and social support, both of which have been found to be protective factors for victimization and perpetration of IPV.[13]

Another organizational approach is the *United States Air Force Suicide Prevention Program*. While not explicitly focused on IPV prevention, this program was developed to reduce stigma and social norms that discourage help-seeking among U.S. Air Force personnel. Eleven different prevention initiatives were put into practice within the Air Force to enhance education and training and create policies aimed at promoting help-seeking (e.g., enhanced patient privilege, greater coordination with mental health services, required training on suicide prevention). A longitudinal evaluation of the program showed a 30% reduction in moderate family violence (exposure to repeated instances of emotionally abusive behavior, neglect, or physical or sexual abuse) and a 54% reduction in severe family violence (a pattern of abusive behavior that requires placement of the victim in an alternative environment) in the years after the program launched.[124] The program also significantly lowered rates of suicide.[124] Creating an organizational culture that encourages help-seeking and increases service referrals for individuals and families in distress may benefit not only individuals at risk for suicide but also couples at risk for IPV.

Modify the physical and social environments of neighborhoods. Evidence suggests that changing or modifying environmental characteristics of neighborhoods may be an effective approach for preventing IPV. For example, one study found that residents of an urban public housing development randomly assigned to buildings in proximity to green conditions (i.e., trees and grass) reported significantly lower rates of partner violence in the past year than residents living in proximity to barren conditions.[125] The researchers found that levels of mental fatigue (inattentiveness, irritability, and impulsivity) were significantly higher in buildings next to barren areas and that aggression accompanied mental fatigue.[125] Additionally, research has also shown that green space in urban communities has been linked to higher levels of neighborhood collective efficacy[126] and reductions in violent crime,[127] which is a risk factor for IPV.[119]

Alcohol-related policies represent another potential way to reduce risk for IPV at the neighborhood/community level.[18] Alcohol outlet density, defined as the number of locations where alcohol can be purchased, has been consistently linked to higher rates of IPV.[18] For example, in a population-level survey of U.S. couples, an increase of 10 alcohol outlets per 10,000 persons was associated with a 34% increase in male-to-female partner violence.[128] Policies that work to reduce a community's alcohol outlet density are one example of an approach that might help reduce community rates of IPV.

Strengthen Economic Supports for Families

Rationale

Addressing socioeconomic factors holds great potential for improving a wide range of health outcomes for neighborhoods, communities and states[129] and also has the potential to prevent IPV. Evidence suggests that poverty, financial stress, and low income can increase risk for IPV. Reducing financial stress may decrease potential for relationship conflict and dissatisfaction, which are strong predictors of IPV.[13, 21] In addition, improving financial stability and autonomy could reduce financial dependence on a potential perpetrator and provide alternatives to unhealthy relationships.[21] Studies also show that differences between women and men in education, employment, and income is a risk factor for IPV.[13, 130] Therefore, efforts to improve financial security for families and women's education, employment and income may reduce risk for IPV.[131]

Approaches

Improving household financial security and work-family supports are ways to strengthen economic supports for families and potentially reduce IPV.

Strengthen household financial security. Improving ways to support families in the absence of employment or sufficient wages addresses several risk factors for IPV, including poverty, low income, financial stress, and inequality between women and men. Providing income supplements, income generating opportunities, and decreasing the pay gap between men and women target these risk factors directly. Examples of ways to strengthen household financial security include income supports such as *tax credits* and *child care subsidies*. These are designed to support parental employment, cover necessities, and offset the costs of childrearing as well as improve the availability of affordable high-quality child care to low-income families. *Cash transfers* and other forms of assistance are another way to help families increase household income and meet basic needs (e.g., food, shelter, and medical care).

Strengthen work-family supports. Policies such as *paid leave (parental, sick, vacation)* provide income replacement to workers for life events such as the birth of a child, care of a family member during times of illness, or personal leave to refresh or recover from a serious health condition. Job-protected leave is also available in some states to help IPV survivors attend court hearings, seek medical treatment, or attend counseling. Paid and job-protected leave policies help individuals keep their jobs and maintain income to cover expenses or address other needs.

Potential Outcomes

- Reductions in poverty, financial stress, and economic dependency
- Increases in annual family income
- Reductions in earnings inequality
- Increases in annual earnings for women
- Increases in empowerment of women
- Reductions in relationship conflict
- Increases in relationship satisfaction
- Reductions in IPV

Evidence

There are a number of policies and programs aimed at strengthening economic supports with evidence of impact on risk factors for IPV.

Strengthen household financial security. *Temporary Assistance to Needy Families (TANF)* and the *Supplemental Nutrition Assistance Program (SNAP)* are examples of programs that can strengthen household financial security through providing cash benefits to low-income households. States can administer these programs in ways that maximize their impact on reducing poverty and financial stress, which are risk factors for IPV.[13] For instance, states can implement policies allowing child support payments to be added (versus off-setting) to *TANF* benefits for custodial parents. The *Minnesota Family Investment Program (MFIP)*, for example, focuses on encouraging work, reducing long-term dependence on public assistance, and reducing poverty by continuing to provide financial supports to struggling families after parents have gained employment—e.g., by increasing the "earned income disregard," or the amount of income that is not counted in calculating welfare grants. An effectiveness study of the program, in which families were randomly assigned to *MFIP* or *Aid to Families with Dependent Children (AFDC)*, which was the predecessor of the *TANF* program, found a number of benefits. Families who received *MFIP* showed significant declines in IPV when compared to families receiving *AFDC* at three-year follow up (49% of *MFIP* participants v. 60% of *AFDC* recipients reported abuse during the three-year follow-up), as well as improved marriage rates for parents and improved school performance and reductions in behavior problems for children.[132] This study suggests that increasing income supports to low income families can lead to reductions in IPV.

Research on tax credits (*Earned Income Tax Credit (EITC)* and *Child Tax Credit*), shows that they can help lift families out of poverty, which is a risk factor for IPV, and are associated with long-term educational and health benefits to recipients and their children.[133-134] Analyses of the use of tax credits shows that families mostly use them to cover necessities as well as to obtain additional education or training to improve employability and earning power.[133] Survivors of IPV often experience unemployment or underemployment, economic instability, and poverty as a result of the abuse they experience. The *EITC* is associated with increases in both maternal employment and earnings, both of which can help women leave an abusive relationship.[134]

Microfinance programs provide a range of financial services and opportunities to low-income families often with the goal of improving a community's financial health by empowering women. Microfinance takes many forms ranging from communal borrowing to low- or no-interest startup loans for small, woman-owned enterprises to innovative savings plans. In some projects, microfinance is paired with training for women on relevant job skills, finances, entrepreneurship, and often on empowerment and social issues as well, including issues of including issues of safe sex and IPV. Kim et al.[135] and Pronyk et al.[20] found microfinance in combination with training on social norms and health topics decreased the incidence of past-year physical and sexual IPV among participants in South Africa by almost half after two years in the program, from 11.4% to 5.9% in the intervention group (versus a slight increase in the control group from 9.0% to 12.1%). In addition, program participants showed increases in multiple indicators of female empowerment, compared to the control group.[135] Although microfinance has primarily been studied in low-income settings in other countries, it holds promise for use in the United States. One U.S.-based study implemented a microfinance intervention with low-income, drug-using women involved in the sex trade with promising findings for HIV risk reduction.[136] This study indicates that microfinance interventions may be feasible for implementation in the U.S. and that they have been successful in impacting outcomes with similar risk factors. There are also organizations providing this type of lending in the U.S.

Comparable worth policies. While most states have equal pay laws, these laws vary in terms of their provisions, populations covered, and remedies available to employees. The laws also vary in terms of comparable worth provisions, which determine pay rates according to the skill level, working conditions, effort, and responsibility of positions. While these policies have not yet been evaluated for their impact on IPV, they could potentially have an impact on IPV by increasing economic stability of women and their families given that economic inequality is a known risk factor for IPV victimization.[130] Studies of the potential impact of a national comparable worth policy on earnings inequality show decreases in overall earnings inequality, inequality between women and men, and inequality among women.[137] Recent findings from an analysis of the 2010-2012 Current Population Survey Annual Social and Economic supplement show potential impacts on women's annual earnings, annual family income, and poverty rates even after controlling for labor supply, human capital, and labor market characteristics.[138]

Strengthen work-family supports. Employers can also adopt *paid leave policies* that allow parents to keep their jobs and thus maintain their incomes after the birth of a child, during an illness, or while caring for sick family members. Research demonstrates that women with paid maternity leave are more likely to maintain their current employment with the same employer after the birth of a child,[139] and women who take maternity leave and delay return to work after the birth of a child have fewer depressive symptoms than those who return to work earlier.[140] One study conducted in Australia found that women working during early pregnancy who qualified for paid maternity leave were significantly less likely to experience physical and emotional IPV in the first 12 months postpartum than women not working.[141] This finding suggests that access to paid maternity leave may be protective against IPV, in addition to helping women maintain employment and potentially reduce mental health issues.

Support Survivors to Increase Safety and Lessen Harms

Rationale

IPV survivors can experience long-term negative health outcomes, including HIV and other sexually transmitted infections, chronic pain, gastrointestinal and neurological disorders, substance abuse, depression and anxiety, PTSD, eating and sleep disorders, chronic diseases, suicide and homicide.[35-36] IPV is also associated with unplanned pregnancy, preterm birth, low birth weight, and decreased gestational age.[35] Furthermore, individuals who have experienced violence and their dependent children are also at increased risk for housing instability and homelessness. *The Violence Against Women Reauthorization Act of 2013*[142] and the *Family Violence Prevention and Services Act*[143] address these issues by putting in place various supports for survivors. Denial of housing based on an individual's status as a victim of abuse and lease termination as a result of violence are now prohibited. However, obstacles to safe and affordable housing still remain when leaving a relationship.[144-145] Efforts to address the psychological, physical, emotional, housing and other needs of survivors and their children may help prevent future experiences of IPV and may lessen or reduce negative consequences experienced by IPV survivors.

Approaches

The current evidence suggests the following approaches to prevent future experiences of IPV and lessen or reduce the negative consequences experienced by IPV survivors:

Victim-centered services include shelter, hotlines, crisis intervention and counseling, medical and legal advocacy, and access to community resources to help improve outcomes for survivors and mitigate long-term negative health consequences of IPV. Services are based on the unique needs and circumstances of victims and survivors and coordinated among community agencies and victim advocates.

Housing programs that support survivors in obtaining rapid access to stable and affordable housing reduce barriers to seeking safety.[22] Once this immediate need is met, the survivor can focus on meeting other needs and the needs of impacted children. These programs can include access to emergency shelter, transitional housing, rapid re-housing into a permanent home, flexible funds to address immediate housing-related needs (e.g., security deposits, rental assistance, transportation), and other related services and supports.

First responder and civil legal protections. These approaches provide increased safety for survivors and their children after violence has occurred. Included here are law enforcement efforts designed to help survivors and decrease their immediate risk for future violence, orders of protection, and supports for children. These protections address survivors' immediate and long-term needs and safety.

Patient-centered approaches recognize the importance of universal prevention education, screening, and intervention for IPV, reproductive coercion, and other behavioral risks. The U.S. Preventive Services Task Force (USPSTF) recommends screening women of childbearing age for IPV and referring women who screen positive to intervention services.[146] Women may be screened for IPV and other behavioral risk factors (e.g., smoking, alcohol, depression) and may also be screened for reproductive coercion and educated about how IPV can impact health and reproductive choices (contraceptive use, pregnancy, and timing of pregnancy). However, not all survivors disclose experiences with violence and there are also opportunities within health care settings to offer universal education on healthy relationships, potential signs of abuse, and available resources and support. Universal prevention education, screening, and intervention may occur in health care settings but may also be considered in the context of other intervention or program models. Intervention services may include counseling, health promotion, patient education resources, referrals to community services and other supports tailored to a patient's specific risks.

Treatment and support for survivors of IPV, including TDV. These approaches include a range of evidence-based therapeutic interventions conducted by licensed mental health providers to mitigate the negative impacts of IPV on survivors and their children. These interventions are designed to be trauma-informed, meaning that they are delivered in a way that is influenced by knowledge and understanding of how trauma impacts a survivor's life and experiences long-term.[147] Treatments are intended to address depression, traumatic stress, fear and anxiety, problems adjusting to school, work or daily life, and other symptoms of distress associated with experiencing IPV.

Potential Outcomes

- Increases in physical safety and housing stability
- Reductions in subsequent experiences of IPV
- Increases in access to services and help-seeking
- Reductions in short- and long-term negative health consequences of IPV, including injury, PTSD, depression, and anxiety
- Increases in positive parenting behaviors
- Decreases in the use of corporal punishment
- Decreases in verbal and physical aggression and increases in prosocial behavior among children of IPV survivors
- Reductions in IPV homicide and firearm IPV homicide
- Improvements in pregnancy outcomes for women experiencing IPV (i.e., higher birth weights, longer gestational age at delivery)
- Reductions in rates of reproductive coercion and unplanned pregnancy

Evidence

The evidence suggests that having supports and programs in place for survivors of IPV improve short- and long-term outcomes for health and safety.

Victim-centered services. Domestic violence shelters and outreach programs that connect survivors and their families with an advocate provide the survivor with the opportunity to navigate and use community resources more easily than they might be able to on their own. Domestic violence advocacy includes assessing a survivor's individual needs and supporting them in accessing community resources such as legal, medical, housing, employment, child care, and social support services. For children of survivors, advocacy includes meeting their needs around recreation, school supports, and material goods. In a randomized controlled trial of women and their children leaving abusive relationships, Sullivan et al.[148] found that, after 16 weeks of client-centered advocacy services, women experienced less abuse from their former partners at immediate follow-up than control women. Women receiving advocacy services also reported less depression and greater self-esteem than controls, indicating an improvement in IPV survivors' overall safety and well-being.

Housing programs. Washington State's *Housing First* program is an example of a housing program for survivors of IPV. The program connects survivors to advocacy services and flexible financial assistance in order to quickly establish permanent housing and to cover transportation, child care, and other costs needed to establish a sense of safety and stability. In a pilot evaluation, 96% of participants remained stably housed after 18 months. Fully 84% of survivors reported an increase in physical safety for themselves and their children.[149] Although this program has not been rigorously evaluated, these pilot findings indicate that providing stable housing to IPV survivors may reduce risk for homelessness and improve women's ability to keep themselves and their children safe from the abuser.

First responder and civil legal protections. *Lethality Assessment Programs* can be an important tool to help police responding to domestic violence and to decrease risk for survivors. Law enforcement officers responding to the scene of a domestic violence incident use a short risk assessment tool to screen for risk of homicide. The assessment tool includes the partner's access to firearms, the partner's employment status, previous threats, and acts of violence. Survivors who screen at high risk are put into immediate contact with an advocate and are provided safety planning, resources, and medical and legal advocacy. An evaluation of the *Lethality Assessment Program* indicated that at a 7-month follow-up interview, program participants receiving the intervention experienced a significant decrease in severity and frequency of physical and emotional violence. Help-seeking behavior also increased at follow-up and included actions such as applying for, and receiving an order of protection, removing or hiding their partner's weapons, and seeking medical care.[150]

Given that leaving the relationship is one of the most potentially lethal times in an abusive relationship,[151] an increase in safety for survivors leaving relationships is particularly salient. *Supervised Visitation and Exchange* is another example that seeks to decrease risk for survivors and their children by creating a safe space for non-custodial parent-child interaction monitored by a third-party. Flory et al. [152] found participation in a supervised visitation program resulted in a 50% reduction in verbal and physical aggression between custodial and non-custodial parents (from an average of 12 incidents to an average of 6 incidents post-intervention). Additionally, parents referred to supervised services were significantly less likely to use corporal punishment after participation in the program,[153] indicating a potential increase in positive parenting behaviors.

Protection orders (POs) are another support option available to survivors. *POs* are court-ordered injunctions aimed at limiting or prohibiting contact between an alleged perpetrator and survivor of IPV to prevent further violence from occurring.[154] Although the process varies considerably by state, it typically begins with a petition to immediately issue a temporary (or ex parte) order until a hearing can be scheduled for a judge to hear from both parties and evaluate whether issuing a permanent order is justified and what the terms should be.[154] In a review of available research, Benitez et al.[155] concluded that *POs* are associated with lower risk of subsequent violence toward the survivor. For example, Holt et al.[156] examined a large sample of women who had experienced a police-reported episode of IPV and found that women with permanent *POs* experienced an 80% reduction in physical abuse during the follow-up period (compared to women with no *PO*). However, women with temporary *POs* were more likely than women without *POs* to be psychologically abused, highlighting the potential importance of longer-term *POs* at reducing risk for subsequent IPV. In addition, Spitzberg[157] conducted a meta-analysis suggesting that an average of 40% of *POs* are violated, and one study found only a few differences when comparing IPV survivors with and without *POs*; women with *POs* had lower levels of hyperarousal and sexual re-abuse at 6-month follow-up than women without *POs*, but no differences were found for other PTSD symptoms, physical assault, injury, or psychological re-abuse.[158] However, research suggests that having a *PO* significantly increases feelings of well-being among survivors of IPV,[159] making *POs* a potentially important tool in supporting survivors.

Another existing protection for survivors is *reducing lethal means* for people who have been convicted of a crime related to IPV or who have a restraining or *PO* against them. Women are at increased risk for homicide when their violent intimate partner has access to a firearm.[151] Federal law makes it unlawful for certain categories of persons to ship, transport, receive, or possess firearms. The law includes individuals subject to a court order restraining the person from harassing, stalking, or threatening an intimate partner or child of the intimate partner, and persons who have been convicted of a misdemeanor or felony crime of domestic violence. In 2016, the U.S. Supreme Court upheld a lower court's decision that firearms may be removed from the possession of someone found guilty of misdemeanor domestic abuse (Voisine v. U.S., 2016).[160] State laws often mirror federal law and, in some cases, enact policy that further limits access or allows law enforcement to remove or seize firearms. Intimate partner homicide was reduced by 7% in states with laws limiting access to firearms for persons under domestic violence restraining orders.[161] In a multiple time series design study, Zeoli and Webster[162] found that in 46 of the largest U.S. cities with state statutes that reduce access to firearms for individuals with domestic violence restraining orders, intimate partner homicide and firearm intimate partner homicide risk decreased by 19% and 25%, respectively, between 1979 and 2003.

Patient-centered approaches are associated with a number of benefits including reduced IPV. The evidence, however, is mixed, potentially due to variability in the nature of intervention models tested, populations studied, loss to follow-up, and other methodological factors.[163-165] A systematic review of primary care-based interventions for IPV found brief, women-focused interventions delivered mostly in the primary care office by non-physician healthcare workers were successful at reducing IPV, improving physical and emotional health, increasing safety-promoting behaviors, and positively affecting the use of IPV and community-based resources.[166] Other systematic reviews have noted significant benefits of counseling interventions in reducing IPV and improving birth outcomes for pregnant women, reducing pregnancy coercion, and women's involvement in unsafe relationships.[165]

One rigorous study of a prenatal counseling intervention found that women in the intervention group (compared with usual care) were 52% less likely to have recurrent episodes of IPV during pregnancy and postpartum; had reduced rates of very low birthweight infants (0.8% vs 4.6%), and longer mean gestational age at delivery (38.2 weeks versus 36.9 weeks).[167] In another rigorous intervention study conducted in four clinics, family planning counselors asked about IPV and reproductive coercion when determining reason for visit and then assisted patients in identifying strategies specific to the reason for the clinic visit (e.g., offering a more hidden form of birth control if partner has been influencing birth control use; offering emergency contraception if indicated; educating client about local IPV and sexual assault resources and facilitating their use). The control group received standard care consisting of a brief IPV screen without any questions on reproductive coercion and were provided a list of IPV resources. In this study, the intervention group was 71% less likely to experience pregnancy reproductive coercion among female patients who had experienced IPV within the past three months compared to a control group.[168] In a subsequent, larger cluster randomized controlled trial of the intervention across 25 family planning clinics, Miller et al.[169] found improvements in knowledge of partner violence resources and self-efficacy to enact harm reduction behaviors among the intervention group (relative to the control group) at the 12-month follow-up. While there were no differences in IPV or reproductive coercion among the full sample at follow-up, the intervention led to a significant reduction in reproductive coercion among women reporting the highest levels of reproductive coercion at baseline.

Another intervention study embedded an IPV intervention into home visitation programs for pregnant women and new mothers, where women in the intervention group were screened by home visitors who had received special training on IPV and the intervention. If women screened positively for IPV, the nurse delivered a brochure-based empowerment intervention during six sessions of the home visiting program. The intervention consisted of a standardized assessment of the level of danger from IPV, a discussion of safety and response options with the participant, assistance with choosing a response, and provision of referrals to services. Women in the intervention group reported a significantly larger decrease in IPV from baseline to two or more year follow-up than women in a service-as-usual control group.[170]

Treatment and support for survivors of IPV, including TDV. Supportive interventions are associated with improved psychological health and long-term positive impact for survivors of IPV. For example, *Cognitive Behavioral Therapy (CBT)* is an example of a treatment for survivors of IPV who experience PTSD and depression. *CBT* includes treatments such as *Cognitive Processing Therapy (CPT)* to help the patient learn to recognize and challenge cognitive distortions (i.e., negative ways of thinking about a situation that makes things appear worse than they really are). A randomized clinical trial that assessed participants before treatment, six times during treatment, and at a 6-month follow-up, found that women who received *CBT* for treatment of PTSD experienced reductions in PTSD and depression. Reductions in

PTSD and depression, in turn, were associated with a decreased likelihood of IPV victimization at the 6-month follow-up controlling for recent IPV (i.e., IPV from a current partner within the year prior to beginning the study) and prior interpersonal traumas.[171]

Another example is *Cognitive Trauma Therapy for Battered Women (CTT-BW)*, which is a cognitive behavioral approach used with survivors of IPV, who are no longer at risk for violence. Designed in collaboration with survivors and advocates, the goal of *CTT-BW* is to address the negative effects of IPV (e.g., PTSD, depression, anxiety, and emotional and behavioral problems). Of the women who completed treatment, 87% no longer met diagnostic criteria for PTSD, and 83% had depression scores in the normal range at the 6-month follow-up.[172]

Although public health can play a leadership role in preventing IPV, the strategies and approaches outlined in this resource cannot be accomplished by the public health sector alone.

Sector Involvement

Public health can play an important and unique role in addressing intimate partner violence. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate IPV prevention efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing IPV, the strategies and approaches outlined in this resource cannot be accomplished by the public health sector alone.

Other sectors vital to implementing this resource include, but are not limited to, education, government (local, state, and federal), social services, health services, business and labor, justice, housing, media, and organizations that comprise the civil society sector such as domestic violence coalitions and service providers, faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Multiple sectors working simultaneously across several strategies is key to taking a comprehensive approach to prevention. Collectively, all of the sectors can make a difference in preventing IPV by impacting the various contexts and underlying risks that contribute to partner violence.

The strategies and approaches described in this resource are summarized in the Appendix along with the relevant sectors that are well positioned to bring leadership and resources to implementation efforts. For example, many of the approaches and programs for the first two strategies (*Teach Safe and Healthy Relationship Skills and Engage Influential Adults and Peers*) are delivered in educational settings, making education an important sector for implementation. Health departments across the country often work in partnership with school districts, universities, and community-based organizations to implement and evaluate prevention programs in educational settings. Other approaches (e.g., healthy relationship programs for couples and family-based programs) are often delivered in community settings. Through their work with community-based organizations, local and state health departments can also play a leadership role in implementing and evaluating these programs.

Programs to *Disrupt the Developmental Pathways Toward Partner Violence* are implemented in a variety of settings and involve the collaborative work of public health, social services, justice, community organizations, and education. For instance, the social services, education and public health sectors are vital for implementation and continued provision of early childhood and parenting programs. Social services, for instance, can help families receive the skills training and services necessary to promote the physical, cognitive, social, and emotional development of children, thereby preparing youth for long-term academic success and positive behavioral and health outcomes. The public health sector can play a vital role by educating communities and other sectors about the importance of ensuring early childhood programs and continuing research that documents the benefits of these programs on health and development, family well-being, and prevention of violence against peers and dating partners, as this evidence is important in making the case for continued support of these programs for children, youth, and families in need.

The health care, justice, and social service sectors can work collaboratively to support children, youth and families with histories of child abuse and neglect, conduct problems, and prior involvement in violence and crime. As with other prevention programs, local and state public health departments can bring community organizations and other partners together to plan, prioritize, and coordinate prevention efforts and play a leadership role in evaluating these programs and tracking their impact on health, behavioral, and other outcomes.

The business and labor sectors, as well as government entities, are in the best position to establish and implement policies to *Strengthen Economic Supports* and *Create Protective Environments* in workplaces and community settings. These are the sectors that can more directly address some of the community-level risks and environmental contexts that make IPV more likely to occur. Public health entities can play an important role by gathering and synthesizing information, working with other agencies within the executive branch of their state or local governments in support of

policy and other approaches, and evaluating the effectiveness of measures taken. Further, partnerships with domestic violence coalitions and other community organizations can be instrumental in increasing awareness of and garnering support for policies and programs affecting women, children, and families.

Finally, this resource includes victim-centered services, criminal justice and social service protections, and a number of therapeutic approaches to *Support Survivors and Lessen Harms*. Domestic violence advocates, community organizations, and other professionals who work with survivors, in collaboration with justice, housing, social services, and the health care sector, are uniquely positioned to identify and deliver critical intervention support and victim-centered services in a manner that best meets the needs and circumstances of survivors. The health care sector, working with victim advocates and in collaboration with justice and social services, is also uniquely positioned to address trauma and the long-term consequences of IPV. In addition to having licensed providers trained to recognize and address trauma, the health care sector can also coordinate wrap-around behavioral health and social services to address the health consequences of IPV and also the conditions that may increase the risk of repeated violence.

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this resource. In this regard, all sectors can play an important and influential role in supporting healthy intimate relationship behaviors and contexts, and supporting survivors and their families when they do experience IPV.

Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. Timely and reliable data are essential for monitoring the extent of the problem and evaluating the impact of prevention efforts. Data are also necessary for program planning and implementation.

Surveillance data helps researchers and practitioners track changes in the burden of IPV. Surveillance systems exist at the federal, state, and local levels. Assessing the availability of surveillance data and data systems across these levels is useful for identifying and addressing gaps in these systems. The National Intimate Partner and Sexual Violence Survey (NISVS) and the National Crime Victimization Survey (NCVS) are examples of surveillance systems that provide data on IPV. NISVS collects information on IPV, sexual violence, and stalking victimization at both the state and national level, including data on characteristics of the victimization, demographic information on victims and perpetrators, impacts of the violence, first experiences of these types of violence, and health outcomes associated with the violence.[173] The NCVS gathers information from a nationally representative sample of households on the frequency, characteristics, and consequences of criminal victimization among persons aged 12 and older in the United States. The Youth Risk Behavior Surveillance System is another source of data that collects information on TDV victimization (including physical and sexual), sexual violence victimization, youth violence victimization (including bullying) and suicidal behavior among high-school students. This information is available at the local, state, and national levels. In addition, there are data at the local level including school surveys, women's health surveys, criminal justice data and other data that are important in local efforts to monitor the problem of IPV.

It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of this resource. Evaluation data, produced through program implementation and monitoring, is essential to provide information on what does and does not work to reduce rates of IPV and its associated risk and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

The evidence-base for IPV prevention has advanced greatly over the last few decades. However, additional research is needed to evaluate the impact of strategies that we know relate to risk factors for IPV, such as disrupting the developmental pathways to aggression on IPV outcomes directly. Along the same lines, more research is needed to evaluate policies and other efforts at the outer levels of the social ecology on IPV outcomes.[174] Consistent with DVP's *Strategic Vision for Connecting the Dots*, evaluation research could also be advanced by measuring IPV and TDV outcomes in studies that are intended to prevent other forms of violence, such as peer violence, bullying, child abuse and neglect, suicide, sexual violence, and problem behaviors such as drug and alcohol abuse, high-risk sexual behavior, among others.[30] Lastly, it will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in this resource. Most existing evaluations focus on approaches implemented in isolation. However, there is potential to understand the synergistic effects within a comprehensive prevention approach. Additional research is needed to understand the extent to which combinations of strategies and approaches result in greater reductions in IPV than individual programs, practices, or policies.

Conclusion

Intimate partner violence represents a significant public health issue that has considerable societal costs. Supporting the development of healthy, respectful, and nonviolent relationships has the potential to reduce the occurrence of IPV and prevent its harmful and long-lasting effects on individuals, families, and the communities where they live. This Prevention Resource contains a variety of strategies and approaches that ideally would be used in combination in a multi-level, multi-sector approach to preventing IPV. Consistent with CDC's emphasis on the primary prevention of IPV, the current resource includes multiple strategies intended to stop perpetration of partner violence before it starts, in addition to approaches designed to provide support to survivors and diminish the short- and long-term harms of IPV. The hope is that multiple sectors, such as public health, health care, education, business, justice, social services, domestic violence coalitions and the many other organizations that comprise the civil society sector will use this resource to prevent IPV and its consequences.

The strategies and approaches identified in this resource represent the best available evidence to address the problem of IPV. It is based on research which suggests that the strategies and approaches described have demonstrated impact on rates of IPV or on risk and protective factors for IPV. Although the research evidence on what works to stop IPV is not as expansive as it is for other areas (e.g., youth violence), ongoing monitoring and evaluation of existing or newly developed strategies and approaches will create opportunities for building upon the current evidence. As new evidence emerges, it will be incorporated into the resource and used to inform and guide communities seeking to address the problem of IPV. Violence between intimate partners is a costly public health issue, but it is also preventable. Through continued research and evaluation of promising approaches for preventing IPV, we can strengthen our understanding of how to support healthy relationships between intimate partners and alleviate the burden of IPV to society as a whole.

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Appendix: Summary of Strategies and Approaches to Prevent IPV

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		TDV/IPV Perpetration	TDV/IPV Victimization	Risk Factors for TDV/IPV	
Teach safe and healthy relationship skills	**Social-emotional learning programs**				Public Health Education
	Safe Dates	✓	✓	✓	
	Fourth R	✓			
	Expect Respect Support Groups	✓	✓		
	Healthy relationship programs for couples				Public Health Community Organizations
	Premarital Relationship Enhancement Program (PREP)	✓	✓	✓	
	Behavioral Couples Therapy (BCT)	✓		✓	
Engage influential adults and peers	**Men and boys as allies in prevention**				Public Health Education
	Coaching Boys Into Men (CBIM)	✓		✓	
	Bystander empowerment and education				Public Health Education
	Bringing in the Bystander			✓	
	Green Dot	✓	✓		
	Family-based programs				Public Health
	Families for Safe Dates		✓	✓	
Disrupt the developmental pathways toward partner violence	**Early childhood home visitation**				Public Health Healthcare
	Nurse Family Partnership (NFP)			✓	
	Preschool enrichment with family engagement				Social Services Public Health Education
	Child Parent Centers (CPC)			✓	
	Early Head Start (EHS)			✓	
	Parenting skill and family relationship programs				Public Health Education
	The Incredible Years			✓	
	Parent Management Training – Oregon Model			✓	
	Treatment for at-risk children, youth and families				Social Services Justice
	Multidimensional Treatment Foster Care (MTFC)			✓	
	Multisystemic Therapy (MST)			✓	
Create protective environments	**Improve school climate and safety**				Public Health Education
	Shifting Boundaries Building-Level Intervention		✓	✓	
	Improve organizational policies and workplace climate				Business/labor Government (local, state, Federal)
	IPV and the Workplace Training			✓	
	U.S. Air Force Suicide Prevention Program		✓		
	Modify the physical and social environments of neighborhoods				Government (local, state) Business
	Greening urban spaces			✓	
	Alcohol policies (e.g., outlet density)			✓	

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		TDV/IPV Perpetration	TDV/IPV Victimization	Risk Factors for TDV/IPV	
Strengthen economic supports for families	**Strengthen household financial security**				Business/labor Government (local, state, Federal)
	Income supports (e.g., tax credits, child care subsidies, cash transfers)			✓	
	Microfinance programs		✓	✓	
	Comparable worth policies			✓	
	Strengthen work-family supports				Business/labor Government (local, state, Federal)
	Paid leave policies (parental, sick, vacation, job-protected)			✓	
Support survivors to increase safety and lessen harms	**Victim-centered services**				Community Organizations
	Domestic Violence Advocacy Services		✓[2]		
	Housing programs				Government (local, state, Federal)
	Domestic Violence Housing First	N/A[3]	N/A[3]	N/A[3]	
	First responder and civil legal protections				Justice Social Services Government (local, state, Federal)
	Lethality Assessment Programs		✓	✓	
	Supervised Visitation and Exchange		✓	✓	
	Protective Orders		✓		
	Reduce access to lethal means for persons convicted of IPV-related crime or under a restraining or protective order for IPV	✓[4]	✓[4]		
	Patient-centered approaches				Healthcare Public Health
	Education with tailored intervention for specific risks such as reproductive coercion		✓		
	Education and screening in the context of other prevention programs (e.g., home visitation)		✓		
	Treatment and support for survivors of IPV, including TDV				Healthcare Community Organizations
	Cognitive Behavioral Therapy (CBT)		✓[2]	✓	
	Cognitive Trauma Therapy for Battered Women (CTT-BW)	N/A[3]	N/A[3]	N/A[3]	

[1] This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing the specific programmatic activities.

[2] This approach reduces risk for IPV victimization, but is also designed to provide support to survivors and mitigate consequences of IPV.

[3] The program is designed to lessen the harms of violence exposures (e.g., PTSD, depression, behavioral problems).

[4] This approach has an impact on rates of lethal forms of IPV, namely homicide.

For more information

To learn more about preventing intimate partner violence, call 1-800-CDC-INFO or visit CDC's violence prevention pages at www.cdc.gov/violenceprevention.

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