



3605 Vartan Way, Suite 101, Harrisburg, PA 17110
717.545.6400 | PCADV.org

PREVENTION

STATE PA
ACTION
PLAN 2021

TABLE OF CONTENTS

1 INTRODUCTION

3 PREVENTION PLANNING PROCESS

- 4 PCADV and the Pennsylvania Coalition Against Rape (PCAR)

5 HISTORY

- 5 A Brief History of Violence Prevention
- 6 PCADV's History of Violence Prevention

9 WHAT IS PREVENTION

- 9 How PCADV Defines Prevention
- 10 The THRIVE Model

11 RATES AND ROOTS OF VIOLENCE

- 11 Rates of Intimate Partner Violence
- 13 Risk Factors for Intimate Partner Violence
- 14 Roots of Intimate Partner Violence: Oppressions
- 17 Structural Racism as an Example
- 20 A Note on Intersectionality

21 NEEDS ASSESSMENT

- 21 Pennsylvania Needs Assessment
- 22 Findings
- 30 Lessons Learned
- 31 Resource Inventory

32 GOALS, OUTCOMES, AND STRATEGIES

- 34 How PCADV Will Evaluate the Plan

35 SUSTAINABILITY PLAN

The publication was supported by the Grant or Cooperative Agreement Number, NUS4CE002304-01-00, funded by the Center for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

INTRODUCTION

The Pennsylvania Coalition Against Domestic Violence (PCADV) is a statewide collaborative delegation organization committed to ending intimate partner violence (IPV) and all forms of violence against women. Started in 1976, PCADV is the nation's first state domestic violence coalition and, through its network of 59 community-based programs, provides free and confidential services to domestic violence victims and their children in all 67 counties of the Commonwealth. Over the past four decades, these programs have offered safety and refuge to three million victims and their children from every corner of Pennsylvania.

Since PCADV began more than forty years ago, its prevention efforts have seen impressive growth, both geographically and conceptually. PCADV is fortunate to have an abundance of advocates across Pennsylvania dedicated to the uniquely challenging work that is prevention. Continued advancement of prevention would not be possible without the strong advocacy, support, and foundation laid by the history of those working to end violence against women.

Conceptually, PCADV adopted a social justice approach to the prevention and elimination of violence against women and intimate partners. Social justice is the view that all people, regardless of differences, have equal access to safety, equitable rights and resources, and the ability to participate in decisions affecting their lives.¹ Further explained in the section, *What is Prevention*, PCADV believes that intimate partner violence exists because of the larger oppressions that lead to inequities in access to power and resources across groups of people.

DOMESTIC VIOLENCE VS. INTIMATE PARTNER VIOLENCE

Domestic violence and intimate partner violence are used interchangeably in this report.

OPPRESSION

Oppression is the systemic and institutional abuse of power by one group at the expense of others and the use of policies, manipulation, and force to maintain this dynamic. An oppressive system is built on the idea that some groups are better and more superior than others based on arbitrary characteristics. (i.e. race, gender, ability, appearance, etc.).

- Adapted from the Arcus Center for Social Justice Leadership, Kalamazoo College

To develop its second five-year Statewide Action Plan for prevention, PCADV convened a Statewide Leadership Team (SLT). SLT members are state-level leaders representing diverse sectors in government, non-profit organizations, banking, educational institutions, social services, and law. Outlined in this plan are bold goals for the health and safety of all persons and their relationships in Pennsylvania. PCADV envisions this plan as a guiding force for the increased prioritization of prevention.

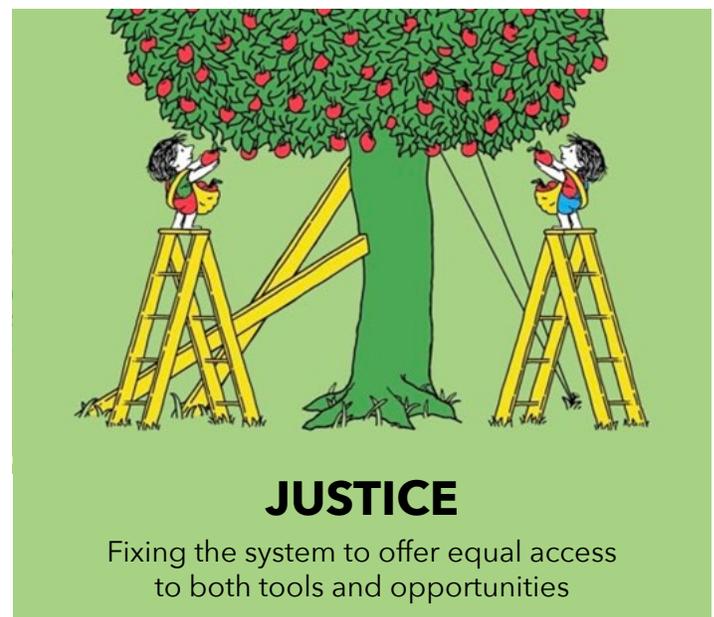
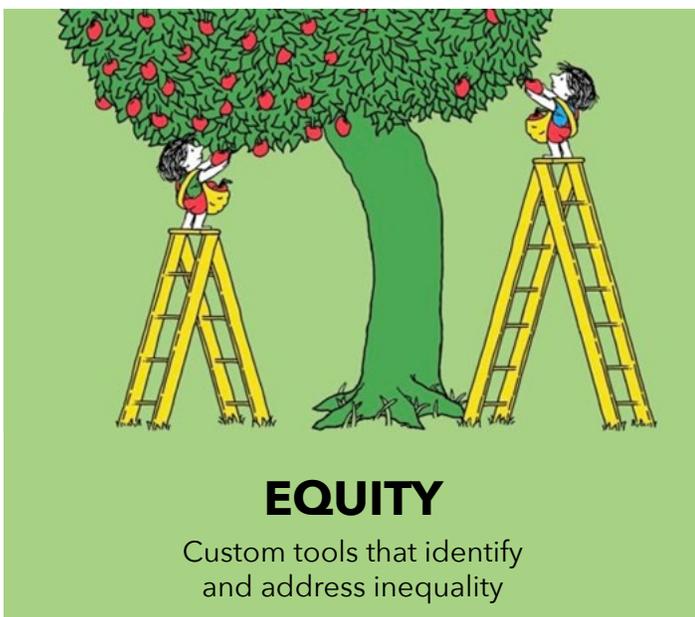
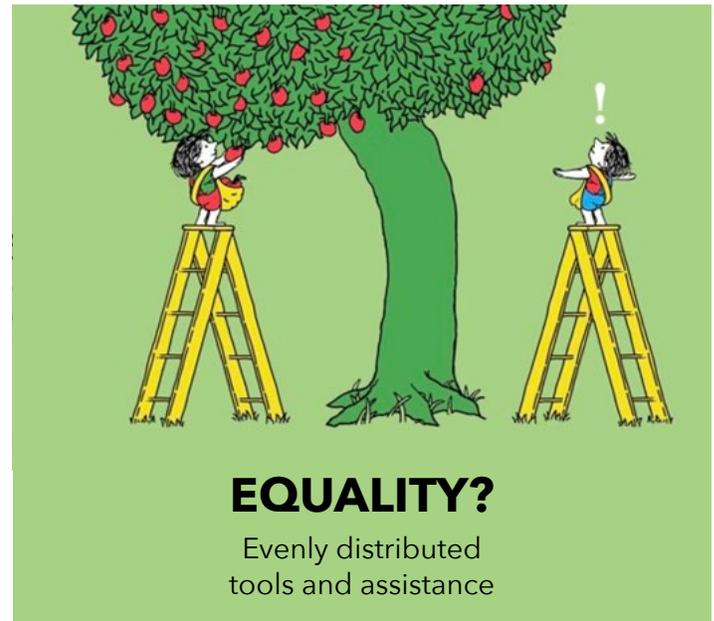
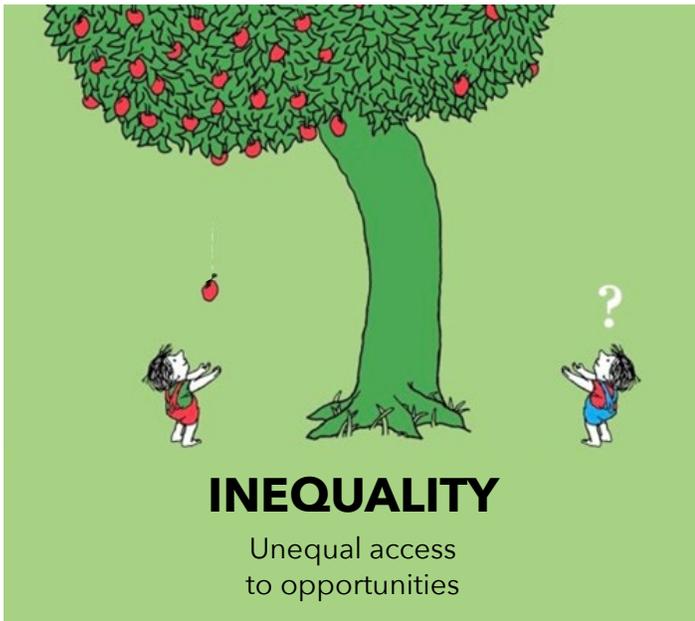
1 American Public Health Association. "Social Justice and Health," APHA. n.d., <https://www.apha.org/what-is-public-health/generation-public-health/our-work/social-justice>.; Stronks et al. "Social justice and human rights as a framework for addressing social determinants of health," World Health Organization Regional Office for Europe. 2016, http://www.euro.who.int/__data/assets/pdf_file/0006/334356/HR-task-report.pdf.

EQUAL VS. EQUITABLE

Equity is giving everyone what they need to be successful. Equality is treating everyone the same.

Equality aims to promote fairness, but it can only work if everyone starts from the same place and needs the same help. Equity appears unfair, but it actively moves everyone closer to success by “leveling the playing field”.

- Amy Sun with *EverydayFeminism.com*



PREVENTION PLANNING PROCESS

PCADV identified a diverse group of statewide stakeholders for inclusion on the SLT to help draft the statewide action plan. SLT partners were chosen based on their company or organization's experience with, and knowledge of risk factors for, IPV. For example, one risk factor for IPV is income inequity; there are members of the banking community on the SLT. PCADV additionally invited organizations that focus on supporting people from underrepresented communities in Pennsylvania and IPV prevention work.

SLT members were trained on PCADV's vision for prevention as well as the THRIVE model.² Members had a firsthand role in crafting the Coalition's statewide action plan. Once this plan is published, the SLT will shift from a team that focuses on planning, toward an action-oriented task force that collaborates on state-level implementation. A list of partners and agencies participating on the SLT can be found at the conclusion of this document.

PCADV additionally surveyed their delegation and local prevention professionals about where to focus prevention efforts over the next five years. A list of these programs can be found at the conclusion of this document.

To strengthen and sustain members of the SLT as part of a long-term collaborative working group, the team developed and agreed upon a vision and mission statement.

Vision statement:

We envision a Pennsylvania that acknowledges both the trauma and resilience of its people, that is inclusive of all persons regardless of their differences and where all persons have equitable opportunities for safety and participation in healthy relationships and communities.

Mission statement:

To increase accessibility for safe and healthy communities by pooling our expertise and influence as a multi-disciplinary action team to increase funding, attention, and resources for the prevention of intimate partner violence in Pennsylvania.



Based on these statements, PCADV and the Statewide Leadership Team began to craft a vision of prevention for the next five years.

² For more information on the THRIVE model, see page 11 of this report.

PCADV AND THE PENNSYLVANIA COALITION AGAINST RAPE

In addition to working with delegation programs and SLT members, PCADV has formed a strong collaborative relationship with its sister organization in Pennsylvania, the Pennsylvania Coalition Against Rape (PCAR). The intersections between IPV and sexual violence are numerous, and the root causes similar, if not the same. Therefore, PCADV and PCAR have agreed to work together toward the prevention of intimate partner and sexual violence in all forms. Below is a joint statement.

How PCADV & PCAR work together

Founded in 1975 and 1976, respectively, PCAR and PCADV were the first state anti-sexual violence and anti-domestic violence coalitions in the nation. Over the decades, our coalitions have worked together, sharing a common goal of supporting survivors and preventing violence across the Commonwealth.

In more recent years, the Centers for Disease Control and Prevention (CDC) has promoted resources like *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence*,³ that clearly show the shared risk and protective factors among teen dating violence, intimate partner violence, sexual violence, youth violence, and more. This has allowed PCAR and PCADV to increase collaboration and communication in order to streamline efforts for our dual programs that work to prevent both domestic and sexual violence. While PCAR has 48 rape crisis centers, PCADV has 59 domestic violence programs, of which we share 34 dual programs.

We have heard from our dual programs that common language, standards, and practices from PCAR and PCADV would allow them to be more successful in preventing multiple forms of violence simultaneously. Because of this, PCAR and PCADV have changed some of our practices to allow for greater information sharing, networking, and collaboration.

Rape Prevention Education & Domestic Violence Prevention Enhancements and Leadership Through Alliances Priorities

PCAR and PCADV are recipients of the Rape Prevention and Education (RPE) and Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) Impact funding, respectively, provided through the CDC.

The DELTA Impact program funds state domestic violence coalitions to implement strategies and approaches designed to prevent IPV at the community and societal levels while also funding local communities to do the same. The RPE program works to prevent sexual violence by providing funding to state health departments in all 50 states and territories in the United States. Both of these grants provide funds to sexual and domestic violence coalitions to prevent IPV at the community and societal levels.

3 Centers for Disease Control and Prevention, *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence*, Wilkins et al. 2014. https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf.

HISTORY

A BRIEF HISTORY OF VIOLENCE PREVENTION

Violence prevention today is a rich field of work and study; however, this has not always been the case. Before the late 1970s, violence was not considered an issue affecting public health – nor was it thought to be preventable.⁴ When traditional public health began making strides in the treatment and prevention of infectious diseases, injuries, and deaths from violence became more prominent.⁵ According to a report by the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention (CDC), “Since 1965, homicide and suicide have consistently been among the top 15 leading causes of death in the United States.”⁶ Below is a brief timeline⁷ illustrating the young history of the violence prevention movement.



4 Department of Health & Human Services USA, and the Centers for Disease Control and Prevention, History of Violence as a Public Health Issue, Linda L. Dahlberg, and James A. Mercy. 2009.

https://www.cdc.gov/violenceprevention/pdf/history_violence-a.pdf.

5 HHS & CDC, History of Violence as a Public Health Issue.

6 Ibid.

7 Ibid.

PCADV'S HISTORY OF VIOLENCE PREVENTION.

PCADV began prioritizing violence prevention in 2007, as recipients of the CDC's DELTA Preparing and Raising Expectations for Prevention (PREP) grant. For four years, PCADV worked towards building its internal capacity to conduct and train on violence prevention. From this, PCADV developed its first five-year statewide violence prevention plan, "Creating Safer Communities: A Plan for Preventing Intimate Partner Violence in Pennsylvania,"⁸ to guide prevention efforts from 2015 to 2020. Developed with a Statewide Prevention Consortium and the Southwest Planning Committee, the first plan emphasized the need for prevention and included goals to increase the awareness of, capacity, and resources for violence prevention in the Commonwealth.

The three overarching goals from this plan were:

1



Increase state and local resources available for the primary prevention of domestic violence across Pennsylvania.

2



Elevate the profile of the primary prevention of domestic violence as a public policy issue.

3



Pennsylvania will work together to bring about the social change necessary to end domestic violence.

In the five years since its initial five-year plan PCADV has made significant progress on those three goals.

1 Increase state and local resources.



Prevention Team

The Prevention Team in 2015 consisted of one full-time manager and two part-time staff. As of 2020, the Prevention Team includes one full-time Director, two Prevention Specialists, one Prevention Evaluation Specialist, and a part-time Training & Technical Assistance Specialist.

8 Pennsylvania Coalition Against Domestic Violence. Creating Safer Communities: A Plan for Preventing Intimate Partner Violence in Pennsylvania. Harrisburg: PCADV, 2015.

Funding for Prevention

In 2015, PCADV was able to increase financial resources for prevention. During this year, PCADV secured: \$130,000 in private foundation money; \$100,000 from a Department of Health Preventative Health and Health Services Block Grant; and received the first PCADV endowment designated to prevention for \$1 million.

Since then, PCADV has continued to focus on funding prevention priorities and, in 2018, was awarded the CDC's DELTA Impact grant of \$2.5 million over five years.

Local Program Capacity

While building its capacity, PCADV reinforced the ability of its local member programs to implement innovative and evidence-informed prevention in their communities. In 2015 PCADV's Prevention Team began hosting regional prevention meetings across Pennsylvania. Those meetings have since been institutionalized and are offered to each of the six regions three times a year, culminating in a statewide summer prevention summit. At these meetings, PCADV trains its local programs on topics including community readiness models, organizational capacity, networking, prevention theory, and evaluation.

PCADV began offering mini-grant opportunities to solidify programs' ability to strengthen their prevention capacity. As PCADV identifies funding for particular initiatives, programs can apply to receive \$5,000 to implement said initiative for one year. Mini-grant programs have included Coaching Boys into Men, Southwest Communications campaign, and the Community Readiness Model. From 2017-2018, PCADV passed through over \$105,000 in mini-grant funding.

2 Elevate prevention as a public policy issue.



Legislative Agenda

After years of educating internal staff, member programs, and the Board, prevention was approved for inclusion on PCADV's 2019-2020 Policy Agenda.

Pay Equity Work

As part of the DELTA Impact grant, PCADV has begun exploring the link between pay inequity and IPV. A report is underway that illustrates how pay inequity impacts known risk factors for IPV and, therefore likely has an effect on rates of IPV.

3 Bring about social change to end domestic violence.



Engaging Men

For seven years, from 2014 through 2020, PCADV's Prevention Team has led a statewide campaign to engage men in the movement to prevent intimate partner violence. In recent years this campaign has grown to include participation from Pennsylvania's Governor, Lieutenant Governor, two Minor League and two Major League baseball teams.

Results from PCADV Annual Prevention Survey

The following are results and responses from the PCADV Prevention Team's 2019 annual prevention feedback survey, delivered to PCADV member programs to evaluate the Prevention Team's leadership and support. PCADV received 62 individual responses, representing each region of the Commonwealth.

As a result of the work of PCADV's Prevention Team:

83%

Over 83% of respondents agree or strongly agree that their individual capacity for prevention has improved.

71%

Over 71% of respondents agree or strongly agree that their organization's capacity for prevention has improved.

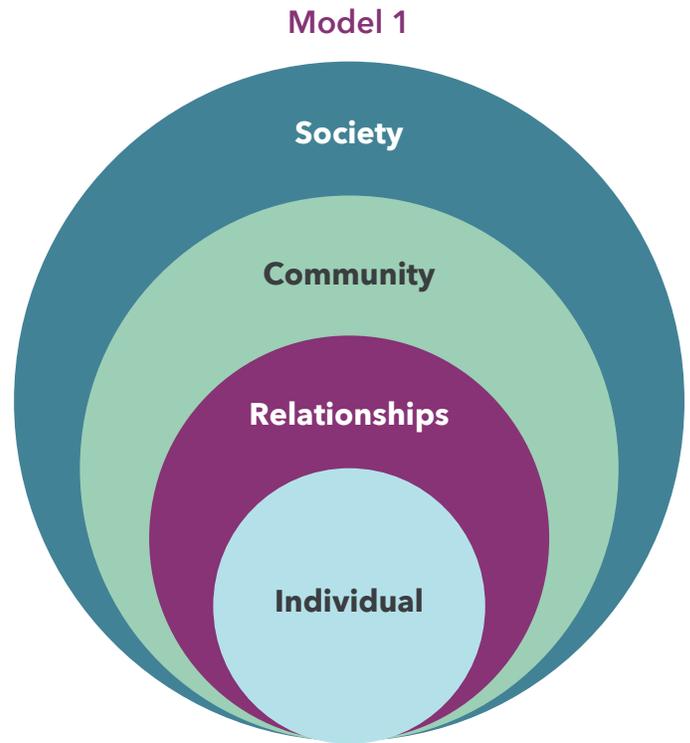
"I do feel that PCADV Prevention staff is very accessible and approachable."

"Great thought-leaders and doing a good job of moving members with a variety of different exposures to prevention work all in the same direction."

"Overall, the training are exceptional and very thought provoking and helpful as well."

WHAT IS PREVENTION

Success in each of the three goals has shaped how PCADV now thinks about prevention. PCADV believes that prevention needs to be addressed holistically. Meaning, in order to prevent IPV, it is not enough to teach individuals about healthy relationships. The social-ecological model (Model 1) shows how individuals are impacted by their relationships, communities, and the policies, culture, and media of the environments in which they live.⁹ Therefore, it is essential for prevention efforts to address the communities and larger society in which individuals live.



Another way to think about this is:



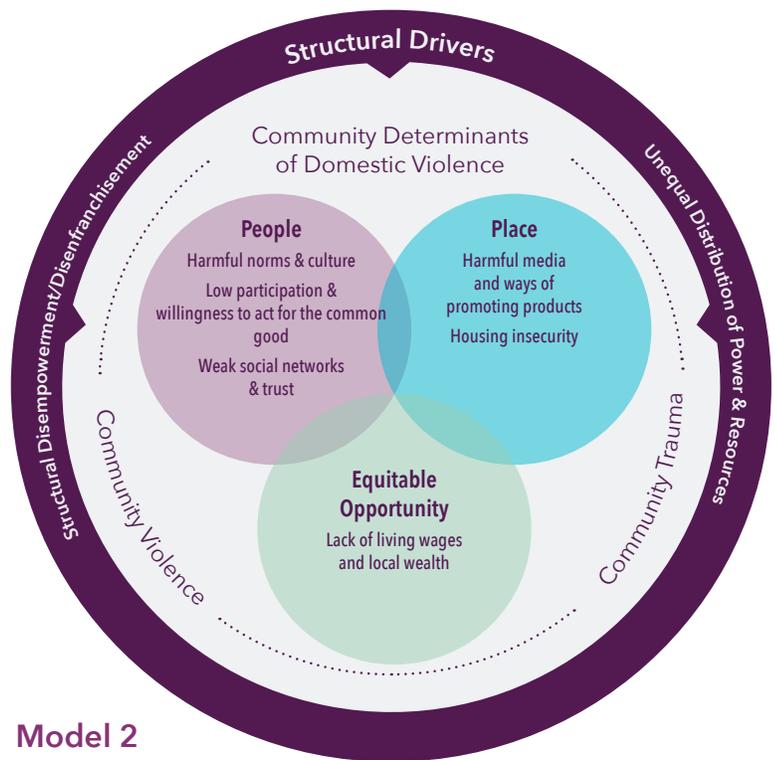
“The health inequities we see are the embodied expressions of social inequity. They are not just about bad choices.

- Nancy Krieger, Harvard School of Public Health

9 Bronfenbrenner, U. (1979). The Ecology of Human Development: Experiments by Nature and Design. Cambridge, Massachusetts: Harvard University Press

From a more detailed perspective, PCADV's Prevention Team adopted the Prevention Institute's THRIVE (Tool for Health and Resilience in Vulnerable Environments) Model (Model 2)¹¹ as a theory for conceptualizing, defining, and implementing prevention efforts. The THRIVE model focuses on community and societal efforts for prevention. THRIVE encourages experts to consider violence prevention under the broader umbrella of intersecting oppressions.

THRIVE is the first model specific to the prevention of IPV that is research-based and illustrates the compounding affect one's environment can have on their likelihood of experiencing IPV.



Model 2

Since introducing and implementing the THRIVE model, PCADV has seen an increase among local program prevention staff and Executive Directors' understanding of, and participation in, prevention.

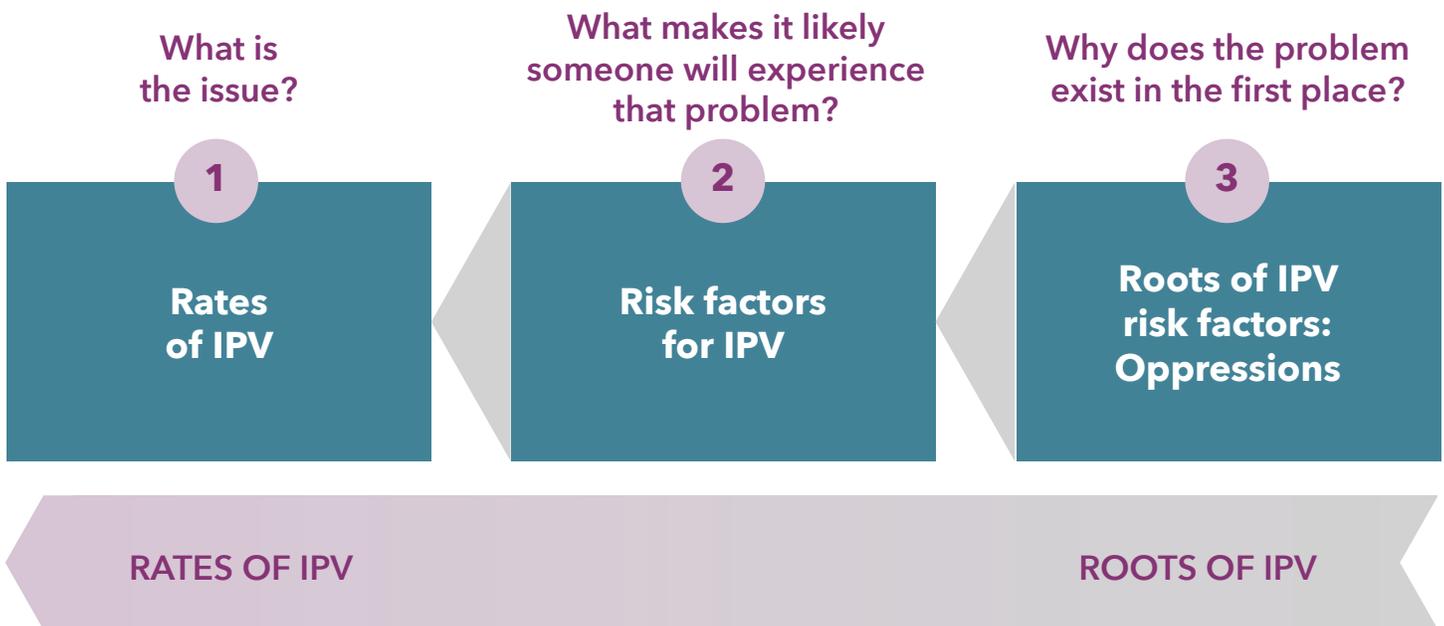
Stemming from the success and understanding of the THRIVE model, PCADV identified an opportunity to institutionalize this work and ensure consistency of prevention efforts among local member programs. PCADV's Prevention Team drafted a new definition of prevention and outlined which characteristics a prevention initiative should have to be engaging in quality prevention work.

Prevention is a process of cultivating environments that are healthy and equitable for all persons by addressing the risk and protective factors associated with intimate partner violence (IPV). The goal of prevention is to reduce both the incidence and prevalence of IPV by eliminating first-time perpetration and victimization of IPV.

Prevention is successful when it is grounded in an understanding of systemic oppressions as the root cause of violence and power and control in relationships. Addressing the risk and protective factors associated with IPV also improves factors related to sexual violence, community violence, child abuse, and neglect, and bullying. Thus, prevention must be multi-sector, implemented with a health equity lens, and consist of efforts at the community and societal levels of the social-ecological model. Plans for implementing prevention should include a strategy for achieving long-term change and regular evaluation of the work to ensure quality.

This new definition was voted on and approved by PCADV's delegation in 2019 and is now part of PCADV's program standards.

RATES AND ROOTS OF VIOLENCE



1 RATES OF INTIMATE PARTNER VIOLENCE

PCADV defines domestic violence as **a pattern of coercive behavior used by one person to gain power and control over another in an intimate or familial relationship.**¹³ Over 10 million people are abused each year in the United States, regardless of gender.¹⁴ Nearly one in four women and one in seven men have experienced severe physical violence,¹⁵ and almost half of all women and men have experienced psychological abuse by a partner in their lifetime.¹⁶ Most survivors of abuse experience some form of IPV for the first time before the age of 25.¹⁷

Specific to the Commonwealth of Pennsylvania, the statistics are no different. According to the National Intimate Partner and Sexual Violence Survey (NISVS), the percentage of people living in Pennsylvania who have experienced contact sexual violence, physical violence or stalking by an intimate partner in their lifetime, is nearly equal to the national percentage (37.1% and 37.3%, respectively).¹⁸ In 2019, 109 victims lost their lives to domestic violence in Pennsylvania, 44% of whom were killed by a current or former intimate partner.¹⁹

13 Pennsylvania Coalition Against Domestic Violence. 2020. About Abuse. Accessed 2020. <https://www.pcadv.org/about-abuse/>.

14 Centers for Disease Control and Prevention National Center for Injury Prevention and Control, The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report, Black et al. 2011 https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

15 U.S. Department of Justice, Nonfatal Domestic Violence, 2003-2012, Jennifer L. Truman, and Rachel E. Morgan. 2014. <https://www.bjs.gov/content/pub/pdf/ndv0312.pdf>

16 CDC, The National Intimate Partner and Sexual Violence Survey (NISVS): 2010.

17 Ibid.

18 Centers for Disease Control and Prevention National Centers for Injury Prevention and Control, The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report, Smith et al. 2017.

19 Pennsylvania Coalition Against Domestic Violence. 2020. 2020 Domestic Violence Fatality Report. Harrisburg, PA.

The WHO and the CDC both recognize IPV as a serious – and preventable – public health concern.²⁰ Victims and survivors of IPV often experience multiple and long-lasting negative health consequences as a result of their trauma. These include asthma, irritable bowel syndrome, diabetes, high blood pressure, frequent headaches, chronic pain, difficulty sleeping, activity limitations, poor physical health, and poor mental health.²¹

Domestic violence and its resulting impacts cost the nation nearly \$3.6 trillion over victims' lifetimes.²² According to the Annual Domestic Violence Counts 2019 Census, in one day, 11,336 national and 491 Pennsylvania requests for service went unmet due to lack of resources.²³ Despite this knowledge, there still does not exist adequate resources for the intervention and treatment of IPV, let alone its prevention.

To end domestic violence, in addition to response and treatment resources, a focus must be placed on prevention. IPV damages to our economies and communities, while prevention – by targeting the root causes of IPV – has the potential to create spaces that are healthy and safe for everyone.



- 20 Centers for Disease Control and Prevention. 2018. Intimate Partner Violence. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>; World Health Organization. 2002. World report on violence and health, Krug et al. https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf;jsessionid=2C4DF3E674D8ED10D3753313D6E36DDB?sequence=1.
- 21 Centers for Disease Control and Prevention. Preventing Intimate Partner Violence, CDC.gov. 2019. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>.
- 22 Peterson et al. "Lifetime economic burden of intimate partner violence among U.S. adults." American Journal of Preventive Medicine (2018). 433-444.
- 23 National Network to End Domestic Violence. 2020. 14th Annual Domestic Violence Counts Report. Washington, DC. Retrieved from: [NNEDV.org/DVCounts](https://www.nnedv.org/DVCounts).

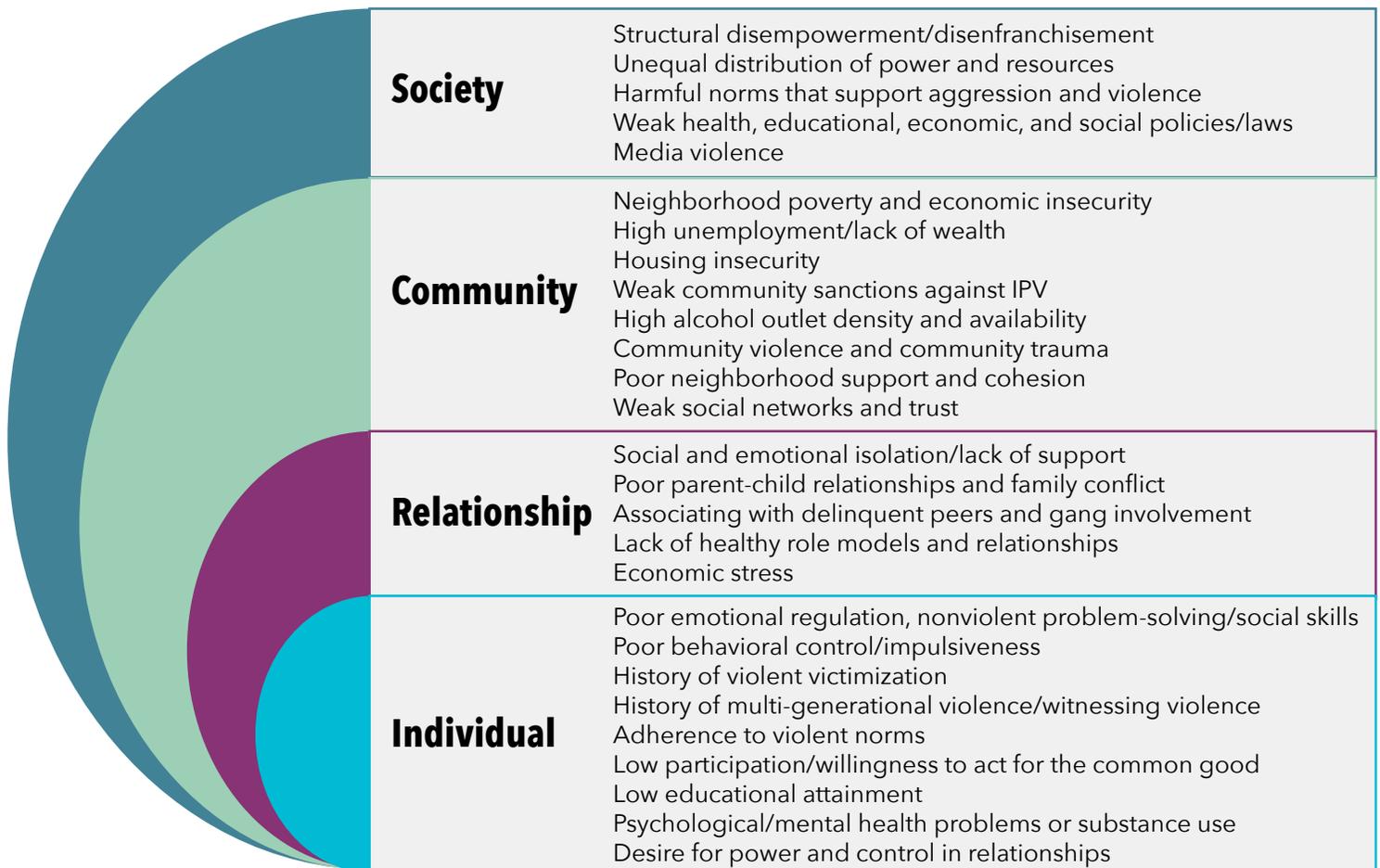
2

RISK FACTORS FOR INTIMATE PARTNER VIOLENCE ²⁴

Risk factors, as defined by the CDC, are “things that make it more likely that people will experience violence.” Risk factors can occur among individuals or within relationships, communities, and societies.²⁴ The more risk factors that exist, the higher the risk of experiencing domestic violence.

For this plan, PCADV is looking primarily at IPV risk factors at the societal and community levels. A list of these risk factors can be seen in the graphic below.

RISK FACTORS FOR INTIMATE PARTNER VIOLENCE



Societal risk factors include the culture of the United States, such as “rules” about what it means to be a man or woman that erase the diversity of individuals’ gendered experiences, and policies that negatively impact people based on their race, education, income, or other factors. Reducing societal risk factors would provide people in the United States equal opportunity and access to choose how to live their healthiest lives.

Community risk factors are important to consider because they are directly impacted by societal risk factors, and they dictate the likelihood that certain communities will experience violence. The more risk factors a community experiences, the more likely their residents are to experience and/or be exposed to multiple forms of violence.²⁵

24 Centers for Disease Control and Prevention, Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence, Wilkins et al. 2014. https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf.

25 Ibid.

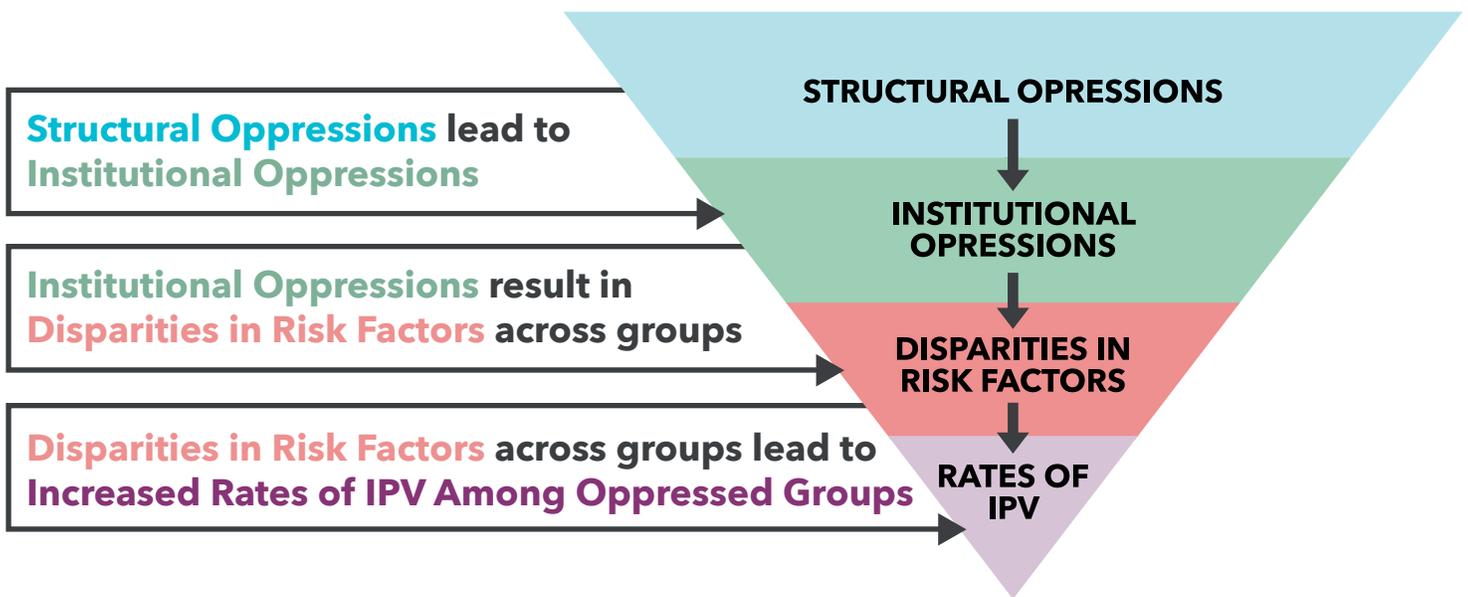
3 **ROOTS OF INTIMATE PARTNER VIOLENCE: OPPRESSIONS**

Domestic violence is fueled by a desire for power and the choice to control one’s intimate partner by taking advantage of, or creating inequality between, the two partners. In a relationship with domestic violence, power and control are unevenly distributed using tactics including isolation, verbal and emotional abuse, financial abuse, sexual violence, stalking, and physical violence.²⁶

In society, a similar unequal distribution of power and control exists among entire groups of people. In a real sense, this uneven distribution of power and resources looks like pay inequity, the school to prison pipeline, unequal public education spending, discriminatory voting laws, lack of affordable housing, and the diminishing accessibility of economic supports (i.e., TANF, WIC, etc.) for families. Less visibly, power inequity can be felt in social norms that offer more opportunities and resources to men over women, citizens over immigrants, white people over people of color, people who are straight or cisgender over people who identify as LGBTQ+, etc. It is here where prevention work most needs to occur on a statewide level.

PCADV believes that advocating for equity of access to power and resources across demographics will have the greatest impact on preventing domestic violence.

As a result of unequal power and resources, people who identify with one or more oppressed groups are more likely to be at risk for domestic violence. Another way to think about this is illustrated in the graphic below.



This graphic demonstrates the compounding relationship between structural and institutional oppressions and the impact those oppressions have on a person’s likelihood of experiencing IPV.

STRUCTURAL OPPRESSION is the suppression “of one social group by a more powerful social group for the social, economic, and political benefit of the more powerful social group.”²⁷ Structural oppression includes the history of treatment towards that group, as well as how current rules and values affect the oppressed group.

Examples of oppressions include (but are not limited to) genderism, racism, sexism, heterosexism, ableism, ageism, classism, language bias, colorism, and antisemitism.

INSTITUTIONAL OPPRESSION is the mistreatment of an oppressed group of people through policies and practices.²⁸ Institutional oppression can be seen in various industries (i.e., education, healthcare) and acts as a barrier to people from oppressed groups accessing equal opportunities.

For example, in some states, recipients of welfare need to meet specific work requirements that fail to take into account the current economy, health, and disabilities of recipients and are often applied in a biased manner that disproportionately affects recipients of color. As a result, welfare recipients receive sanctions that remove their food and health supports, resulting in greater health disparities.

DISPARITIES are the inequalities or differences in health outcomes between groups of people as a result of structural and institutional oppression.²⁹ Disparities can be seen among institutions, and how they affect risk factors for IPV. For example,

- Low-income neighborhoods are more likely to have higher unemployment and poverty rates, lower homeownership and lower educational attainment than middle- and high- income neighborhoods.³³
- Adults from LGBT communities are more likely than adults who do not identify with the LGBT community to lack health insurance.³⁴
- Urban schools with higher concentrations of black and Latino students offer fewer advanced courses and have lower levels of achievement than schools attended by predominately white students in adjacent suburban school districts.³⁵

Bisexual
women are
more than

2X

as likely to
be stalked as
heterosexual women.

Disparities can also be seen among rates of IPV. For example,

- Black women are 35% more likely to experience IPV than white women.³⁰
- The rate of stalking among bisexual women is more than double the rate among heterosexual women.³¹
- Native American women experience significantly higher rates of IPV than women of other ethnicities.³²

27 OpenSource Leadership Strategies. n.d. The dynamic system of power, privilege, and oppression.

28 Carol Cheney, Jeanni LaFrance, and Terrie Quinteros. 2006. “Portland Community College.” Institutionalized Oppression Definitions. <https://www.pcc.edu/illumination/wp-content/uploads/sites/54/2018/05/institutionalized-oppression-definitions.pdf>.

29 Office of Disease Prevention and Health Promotion. Disparities, HealthyPeople.gov. 2020. <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>.

30 Women of Color Network (2006). Communities of Color: Facts & Stats Collection. http://www.doj.state.or.us/wp-content/uploads/2017/08/women_of_color_network_facts_domestic_violence_2006.pdf

31 Centers for Disease Control and Prevention (2010). Fact Sheet on Victimization by Sexual Orientation. <https://www.cdc.gov/violenceprevention/datasources/nisvs/summaryreports.html>

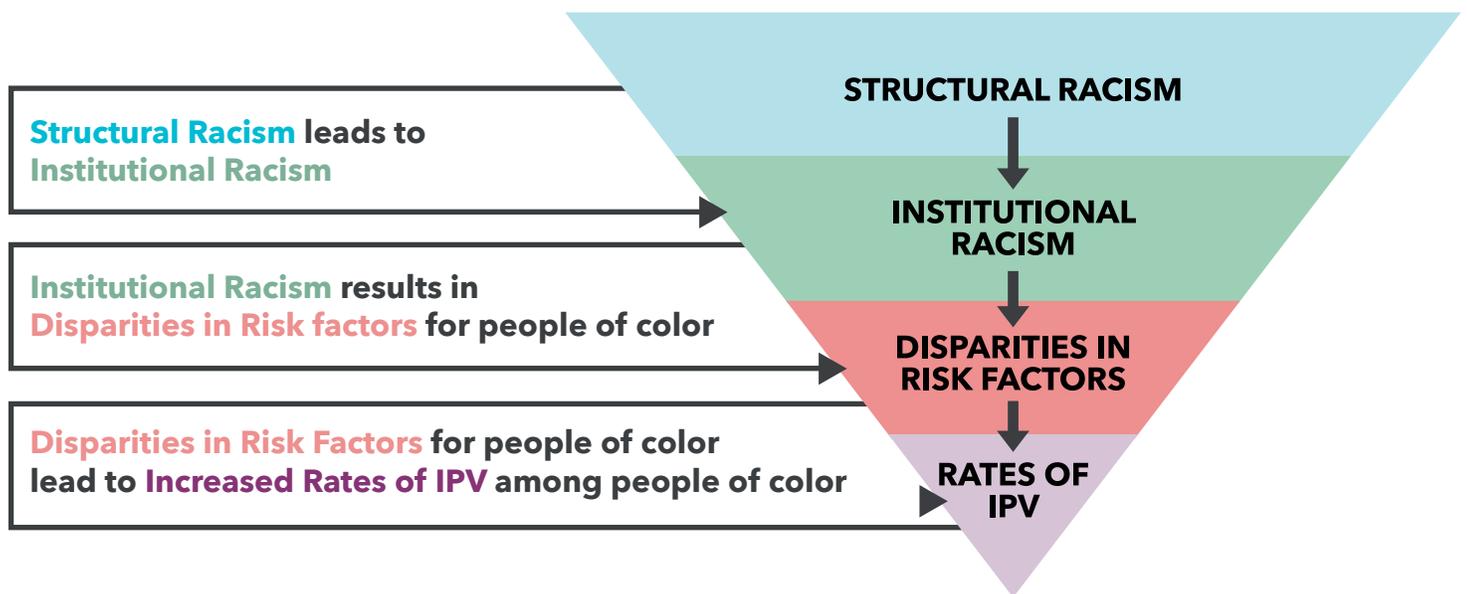
32 Futures Without Violence (n.d.). The Facts on Violence Against American Indian / Alaskan Native Women. <https://www.futureswithoutviolence.org/userfiles/file/Violence%20Against%20AI%20AN%20Women%20Fact%20Sheet.pdf>

33 Acevedo-Garcia D, McArdle N, Osypuk TL, Lefkowitz B, Krimgold BK. Children Left Behind: How Metropolitan Areas Are Failing America’s Children. In: diversitydata.org; 2007.; Diez Roux AV, Merkin SS, Arnett D, Chambless L, Massing M, Nieto FJ, et al. Neighborhood of residence and incidence of coronary heart disease. N Engl J Med 2001;345(2):99-106.

34 Krehely, J. (2009, December 1). How to close the LGBT health disparities gap. Center for American Progress. Retrieved from <https://www.americanprogress.org/issues/lgbtq-rights/reports/2009/12/21/7048/how-to-close-the-lgbt-health-disparities-gap/>.

35 Squires GD, Kubrin CE. Privileged Places: Race, Uneven Development and the Geography of Opportunity in Urban America. Urban Studies 2005;42(1):47-68.; Williams DR, Collins C. Racial residential segregation: a fundamental cause of racial disparities in health. Public Health Rep 2001;116(5):404-16.

STRUCTURAL RACISM AS AN EXAMPLE



Understanding structural racism requires looking at the history of treatment toward people of color. America has a history of mistreatment toward black, Indigenous, and people of color, including the exploitation of Indigenous people and their land,³⁶ the enslavement of Africans,³⁷ the stealing of Mexican lands,³⁸ concentration camps for Japanese Americans,³⁹ and limits set on immigration,⁴⁰ particularly from countries that are primarily black and brown.

Structural racism also includes dominant cultural rules, values, and stereotypes,⁴¹ which, in addition to history, can be seen in inequities among large groups of people. For example, the use of stereotypical racial characters, such as caricatures of Indigenous people for sports teams, or the depiction of black women as caregivers or maids on food products and in movies.

Black women are 35% more likely to experience IPV than white women.

39% of Native American women identified as victims of IPV in their lifetime—higher than any other race or ethnicity

36 National Public Radio et al. 2017. Discrimination in America: Experiences and views of Native Americans. <https://www.npr.org/documents/2017/nov/NPR-discrimination-native-americans-final.pdf>.

37 Ariela Gross, Alejandro de la Fuente. 2020. "The history of slavery remains with us today." The Washington Post, March 9. <https://www.washingtonpost.com/outlook/2020/03/09/history-slavery-remains-with-us-today/>.

38 Garza, Pedro. 2017. "Mexicans didn't immigrate to America -- We've always been here." <https://www.forbes.com/sites/realspin/2017/04/11/mexicans-didnt-immigrate-to-america-weve-always-been-here/#11b6c30b245d>.

39 U.S. History Pre-Columbian to the New Millenium. 2019. Japanese-American Internment. <https://www.ushistory.org/us/51e.asp>.

40 U.S. Citizenship and Immigration Services . 2019. Overview of INS History. <https://www.uscis.gov/history-and-genealogy/our-history/overview-ins-history>.

41 Cheney. Institutionalized Oppression Definitions.

Consider how racism reveals itself in the following institutions, and the impact those practices and policies have on the lives of people of color. Resulting from these institutional policies are factors that, if experienced, increase the likelihood that someone will experience IPV.



Institution: Housing

Practice: Redlining. A financial practice of denying loans, financial support or other services to people of color in an attempt to segregate them to specific communities.⁴²

Disparity: In an analysis of financial institution mortgage lending practices in major metropolitan areas, one report found that black mortgage applicants, across 48 cities, were turned away at higher rates than white applicants.⁴³

Result: From 1934-1942 households of color received only 2% of Federal Housing Administration (FHA) loans.⁴⁴ Today, only 45% of Black households and 47% of Latinx households are homeowners, compared to 73% of white households.⁴⁵

Result: Children of homeowners are “less likely to drop out of school, get arrested, or become teen parents than children of families who are renters.”⁴⁶ The impact of redlining also leads to increased experiences of neighborhood poverty and diminished economic opportunities.⁴⁷

Connection to IPV: Low educational achievement, economic stress, and neighborhood poverty are all known risk factors for IPV.



Institution: Education

Practice: School-to-prison pipeline. A zero-tolerance norm in schools that criminalizes students for minor offenses and increasingly funnels children of color from schools into the criminal justice system.⁴⁸

Disparity: Black children constitute 18% of students, but account for 46% of those suspended more than once.⁴⁹

Result: The impact of the school-to-prison pipeline affects a child of color’s ability to remain in school, obtain their diploma or degree, and make money to support themselves and their families. It also increases the likelihood they will be involved in the criminal legal system and less able to engage in their communities as adults.⁵⁰

Connection to IPV: Low educational achievement, lack of social support, diminished economic opportunities, and high unemployment rates are all known risk factors for IPV.

42 Terry Gross. 2017. A ‘forgotten history’ of how the U.S. government segregated America. National Public Radio, May 3. <https://www.npr.org/2017/05/03/526655831/a-forgotten-history-of-how-the-u-s-government-segregated-america>.

43 Emmanuel Martinez, Aaron Glantz. 2018. How Reveal identified lending disparities in federal mortgage data. The Center for Investigative Reporting. <https://www.revealnews.org/article/how-we-identified-lending-disparities-in-federal-mortgage-data/>.

44 Hanchett, Thomas W., “The Other ‘Subsidized Housing’: Federal Aid to Suburbanization 1940s-1960s.” in John F. Bauman, Roger Biles and Kristin M. Szylvian, *From Tenements to the Taylor Homes: In Search of an Urban Housing Policy in Twentieth Century America* (University Park, Pa.: Pennsylvania State University Press, 2000), pp. 163-179.

45 Demos, *The Racial Wealth Gap*, Laura Sullivan, Tatjana Meschede, Lars Dietrich, and Thomas Shapiro. 2015. https://www.demos.org/sites/default/files/publications/RacialWealthGap_1.pdf.

46 Richard Green and Michelle White. 1994. *Measuring the Benefits of Homeowning’s Effect on Children*. Chicago. <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.197.257&rep=rep1&type=pdf>.

47 Danyelle Solomon and Connor Maxwell. 2019. “Systematic Inequality: Displacement, Exclusion, and Segregation.” Center for American Progress. <https://www.americanprogress.org/issues/race/reports/2019/08/07/472617/systemic-inequality-displacement-exclusion-segregation/>.

48 Marilyn Elias. 2013. “The school-to-prison pipeline.” *Teaching Tolerance*. <https://www.tolerance.org/magazine/spring-2013/the-school-to-prison-pipeline>.

49 Marilyn Elias. “The School-to-prison pipeline.”

50 ACLU Washington. n.d. “What are the impacts of suspension and expulsion?” *Impact of the school to prison pipeline*. <https://www.aclu-wa.org/pages/impacts-school-prison-pipeline>.



Institution: Economy

Policy: Unequal pay for women of color. Regardless of education level, industry or experience, women of color continue to be paid less than their white male counterparts.⁵¹

Disparity: Black women are paid 39% less than white men, and 21% less than white women.⁵²

Result: Income inequality is itself a risk factor for IPV and can lead to experiencing neighborhood poverty, debt and less economic opportunities and overall wealth.

Connection to IPV: Societal income inequality, neighborhood poverty, and diminished economic opportunities are all risk factors for IPV.

Structural racism leads to institutional racism. Institutional racism, as demonstrated, is carried out through inequitable policies and practices that unfairly target and create disparities among people of color. The disparities that result are often themselves risk factors for IPV. In these examples, structural racism, historically and presently, has a disparate impact on people of color's exposure to risk factors for IPV.

- 1 in 2 multiracial non-Hispanic women (53.8%) have been the victim of rape, physical violence, and/or stalking by an intimate partner in their lifetime.⁵³
- Black women experience more than twice the homicides of white women, 55% of which, the CDC estimates, is directly related to IPV, and higher rates of domestic violence than white women.⁵⁴
- 1 in 3 Latinas have experienced intimate partner violence.⁵⁵
- American Indian and Alaska Native women experience assault and domestic violence at much higher rates than women of any other ethnicity.⁵⁶

51 Institute for Women's Policy Research. 2020. Pay Equity & Discrimination . <https://iwpr.org/issue/employment-education-economic-change/pay-equity-discrimination/>.

52 National Partnership for Women & Families . 2020. "Black women and the wage gap ." National Partnership for Women & Families . March. <https://www.nationalpartnership.org/our-work/resources/economic-justice/fair-pay/african-american-women-wage-gap.pdf>.

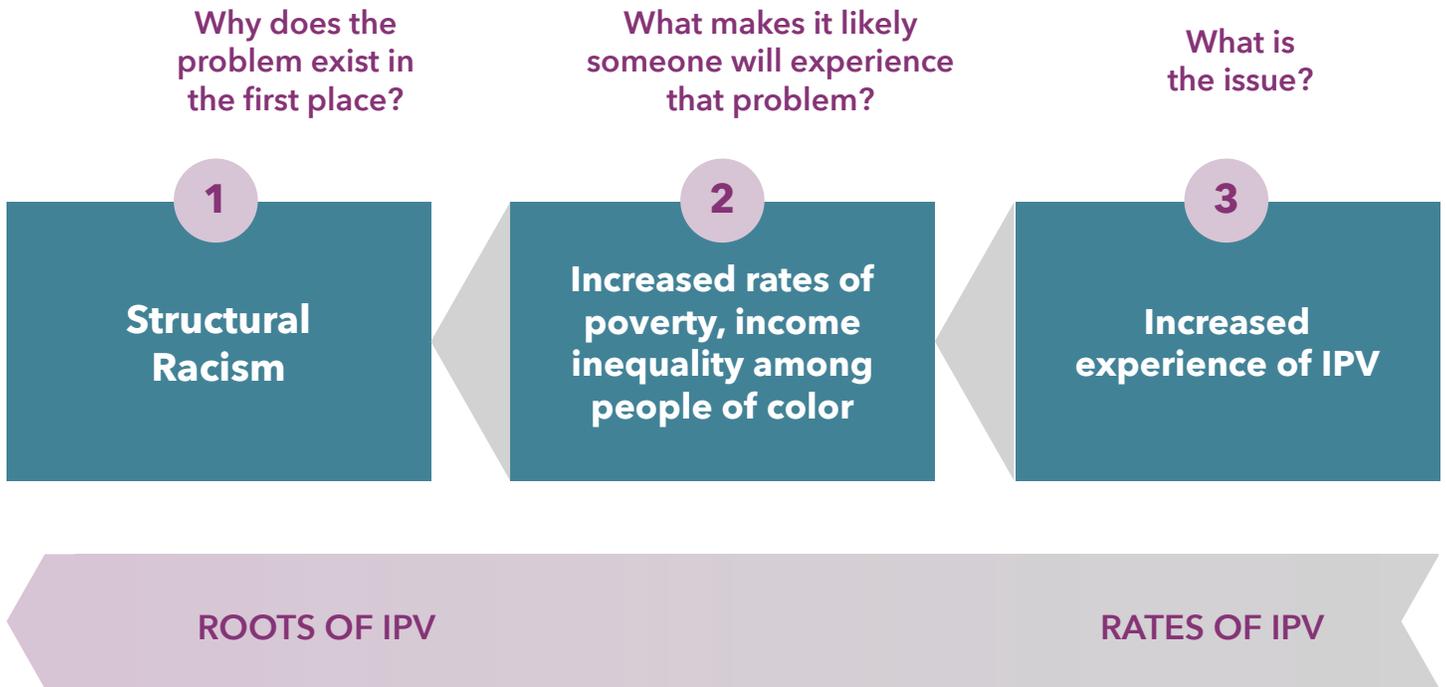
53 CDC. NISVS.

54 Petrosky et al. 2017. Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence – United States, 2003-2014. Morbidity and Mortality Weekly Report. <https://www.cdc.gov/mmwr/volumes/66/wr/mm6628a1.htm#suggestedcitation>.

55 CDC. NISVS.

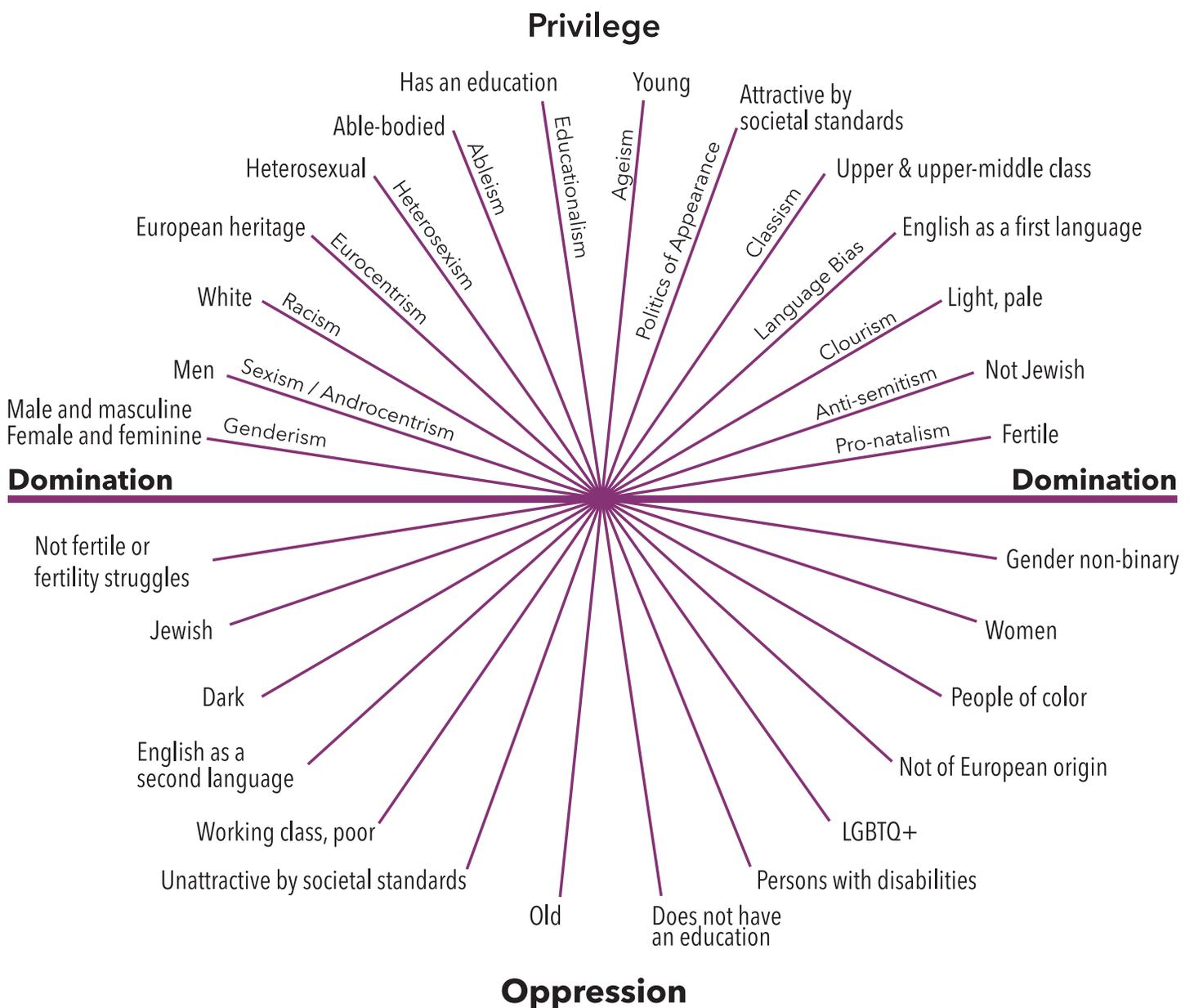
56 United States Department of Justice. 2000. Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women. <https://www.ncjrs.gov/pdffiles1/nij/183781.pdf>.

Looking again at the same image from page 11, in reverse, one can see the impact structural racism has on people of color and their likelihood of experiencing IPV.



A NOTE ON INTERSECTIONALITY

This graphic⁵⁷ illustrates some of the different oppressions that people experience. These oppressions are matched with their corresponding privileges. It is important to note that one person can have multiple identities and therefore can experience multiple oppressions. The overlapping of one’s identities and how that impacts how the world interacts with them, is known as intersectionality. As IPV does not solely target or impact women, the elimination of root causes cannot solely focus on one oppression, like sexism. For IPV prevention work to be successful and sustainable, there needs to be work toward eliminating sexism in addition to other oppressions like racism, classism, heterosexism and nativism, to name a few.



57 Adapted from: Morgan, K. P. (1996). Describing the emperor's new clothes: Three myths of educational in(equality). In Diller, A, Houston, B., Morgan, K.P., & Ayim, M. Editor (Ed.), The gender question in education, theory, pedagogy, & politics (pp. 105-122). Boulder, CO: Westview.

NEEDS ASSESSMENT

The information from this section was taken directly from PCADV's report: *Needs Assessment on Risk Factors for Intimate Partner Violence within Pennsylvania*,⁵⁸ prepared by HPW Associates. This report can be requested from PCADV's Prevention Team at preventionteam@pcadv.org.

PENNSYLVANIA NEEDS ASSESSMENT

It should now be clear that PCADV understands prevention as an effort that needs to be taken on societally and within communities to achieve sustainable change. Efforts should focus on reducing risk factors for IPV caused by larger structural oppressions. Theoretically, this makes sense, but practically, this does not show where or which efforts PCADV should focus on to see the most significant impact.

Taking this into consideration, PCADV hired HPW Associates, an evaluation firm, to conduct a review of community-level risk factors for IPV in Pennsylvania. The community risk factors HPW explored were poor neighborhood support and cohesion, neighborhood poverty, high unemployment rates, diminished economic opportunities, and substance use. PCADV's Prevention Team hoped the findings would answer the following questions:

- Where do community-level risk factors most impact Pennsylvanians?
- Are there any trends across the Commonwealth?
- Which community-level risk factors should be prioritized over the next five years?

Methods

To measure the prevalence of community-level risk factors across Pennsylvania, HPW used indicators from publicly available data sources. For this report, indicators are defined as markers that, when put together, provide a clearer picture of the risk factors. For example, neighborhood poverty is not a measure on its own. However, if the percentage of adults in poverty is known, and the percentage of children in poverty is known – that can paint a picture of neighborhood poverty overall. Table 1 shows the indicators used to measure community-level risk factors, and the secondary data sources from where the information was gathered.

Table 1

RISK FACTOR	DATABASE	INDICATORS
Poor neighborhood support and cohesion	CHR&R ⁵⁹	Violent crime rate
		Social association rate ⁶⁰
		Food environment index ⁶¹
Neighborhood poverty	American Community Survey ⁶²	Percent of population in poverty
	CHR&R	Percent of children in poverty
Diminished economic opportunities	CHR&R	Income inequality ratio ⁶³
		Severe housing problems ⁶⁴
		Median household income
Substance use ⁶⁵	CHR&R	Excessive drinking rates ⁶⁶
		Alcohol-impaired driving deaths
		Drug Overdose deaths

Indicators data were used to identify counties with the highest overlap of community-level risk factors. Once these counties were identified, HPW reviewed Community Health Needs Assessments (CHNA) for each. HPW also worked with PCADV to develop a list of key informants for interviews to gain the perspective of local domestic violence service providers. Their opinions helped to confirm or identify additional risk factors and what they feel are barriers to successful prevention efforts in the area.

FINDINGS

The results of the report are divided into three sections:

Section A looks at six Pennsylvania counties. These six counties were ranked within the top ten counties in Pennsylvania for at least two of the indicators and a high percentage of populations considered most at-risk for IPV.

Section B follows the same methodology, but only includes rural counties in the rankings. Pennsylvania has the third largest rural population in the nation, twenty-six percent of the state's 12.8 million residents live in rural Pennsylvania.⁶⁷ As a result, PCADV wanted to ensure representation of those communities, regardless of their demographics, because rural communities are also underrepresented in IPV literature.

Section C does not share specific rates but visually illustrates prevalence rates for each of the chosen risk factors across all counties in Pennsylvania.

59 CHR&R refers to the County Health Rankings and Roadmaps surveys collected annually by the Robert Wood Johnson Foundation. <https://www.countyhealthrankings.org/reports/county-health-rankings-reports>

60 Number of membership associations per 10,000 population

61 Ranking of food environment accounting for access to healthy foods (distance an individual lives from a grocery store) and food insecurity (cost) - highest (best) recorded index is 8.9

62 The American Community Survey is conducted monthly by the United States Census Bureau. <https://www.census.gov/programs-surveys/acs/about.html>

63 Income inequality ratio is the income of those at the 80th percentile to those at the 20th percentile. Eightieth percentile income is the level at which 20.0% of households have a higher income, 20th percentile is the level at which 20.0% of households have a lower income. A higher ratio indicates greater division between those in the higher income bracket and those in the lower income bracket.

64 Severe housing problems are understood as housing units (HU) where: HU lacks complete kitchen facilities, HU lacks complete plumbing, HU is overcrowded, and HU is severely cost burdened.

65 Substance use was used as a proxy indicator for alcohol outlet density as data specific to the latter were not readily available for analysis. Rather, data on excessive drinking rates, alcohol-impaired driving deaths, and drug mortality rate were instead retrieved and used to determine prevalence of risk specific to substance use. Please note, substance use is an individual level risk factor for IPV, not a community level risk factor.

66 Excessive drinking is understood as the percentage of adults reporting binge or heavy drinking.

67 The Center for Rural Pennsylvania (n.d.). Rural / Urban PA. Retrieved from https://www.rural.palegislature.us/rural_urban.html

Section A - Top Five Counties & Dauphin County

Table 2 shows prevalence rates for the top five Pennsylvania counties with the highest overlap in indicators of risk factors for IPV. Dauphin County was included as a case study.

Table 2

County		Phila- delphia	Delaware	Fayette	Berks	Lacka- wanna	Dauphin	Other*
Risk Factor	Indicator	# or Percent						
Support and Cohesion	Social association rate	7.5%	8.2%	13.9%	11.8%	12.7%	19.0%	27.8%
	Violent crime rate (# per 100k population)	1001.5	396.1	204.6	299.9	213.4	402.8	66.9
	Food environment index	6.9	8.1	7.2	8.7	8.1	7.6	8.9
Poverty	Percent of population in poverty	25.8%	10.4%	18.8%	13.6%	15.4%	13.2%	6.1%
	Percent of children in poverty	31.9%	13.1%	28.0%	17.0%	20.4%	18.6%	6.5%
Unemployment	Unemployment rate	6.2%	4.5%	6.9%	4.6%	5.1%	4.5%	3.6%
Economic Opportunities	Income inequality ratio	6.7	4.9	5.1	4.4	5.0	4.1	3.1
	Severe housing problems	24.2%	17.4%	12.7%	16.1%	16.0%	14.1%	7.5%
	Median household income	\$40,193	\$73,637	\$42,892	\$61,022	\$49,082	\$61,229	\$96,803
Substance Use	Excessive drinking rates	22.1%	18.7%	17.6%	19.5%	21.4%	18.8%	17.6%
	Alcohol-impaired driving deaths	18.3%	28.9%	27.8%	29.1%	31.3%	26.0%	9.1%
	Drug overdose mortality rate	50.1%	42.1%	52.8%	21.5%	35.2%	27.7%	8.9%

The county **most at risk** for each risk factor by indicator *has been highlighted.*

*In order to show magnitude for these counties in relation to others in the state, the county with the lowest at-risk indicator has been included in the "Other" column.

Only Fayette County is rural, according to the Center for Rural Pennsylvania.⁶⁸ Besides Fayette, which is in southwestern Pennsylvania, all the other counties are in the eastern region of the state, three of them concentrated in the southeast specifically. Philadelphia has the highest overlap of indicators for community-level risk factors. Each of the counties included in this list experience double to quadruple the rate of poverty and children in poverty. Most have double the rate of severe housing problems and significantly higher rates of income inequality.

Dauphin County demonstrates some of the inherent difficulties in measuring rates of IPV. Dauphin County has a higher proportion of populations at-risk for experiencing IPV, but a lower prevalence of risk factors. HPW notes this as a challenge of the ability to use several indicators to measure community-level risk factors for IPV. Additionally, and seen often in Pennsylvania counties, there are specific areas within a county (i.e., the City of Harrisburg in Dauphin County) where the data do not necessarily match that of the county as a whole. Overall, this speaks to a need for improved methods to measure IPV risk and prevalence.

Table 3 shares demographics known to be at higher risk for IPV, and their representation among each of the six counties.

Table 3

County		Phila- delphia	Delaware	Fayette	Berks	Lacka- wanna	Dauphin	PA*
Risk Factor	Indicator	Number or Percent						
Gender	Percent of women	52.7%	51.9%	50.5%	50.8%	51.6%	51.5%	51.0%
Race	Percent African-American	40.9%	21.4%	4.6%	4.2%	2.7%	17.4%	10.8%
Ethnicity	Percent Hispanic (not African-American)	14.8%	3.8%	1.2%	21.0%	7.5%	9.2%	7.3%
Age	Percent 18 years old or younger	21.8%	22.0%	19.3%	22.5%	20.3%	22.5%	20.8%
Education Level	Percent high school diploma***	79.0%	89.0%	85.0%	87.0%	88.0%	80.0%	87.0%
Household	Percent single parent household with children	59.0%	33.0%	41.0%	36.0%	37.0%	41.0%	34.0%
Same-Sex**	Number per 1,000 households	8.0	4.5	2.4	3.7	3.7	6.8	4.4

Counties with **higher than state averages** have been highlighted.

*The statewide average for each demographic has been included in the "PA" column.

**Same-sex couples per 1,000 households

*** Percent high school diploma only

In addition to secondary data, HPW reviewed CHNAs and interviewed stakeholders from all six counties in an attempt to identify any additional factors they feel impact IPV in their communities and compare those experiences locally to county-level data. A detailed write-up of community health problems described by each stakeholder can be found in HPW's full report, which can be made available upon request.

Major themes from stakeholders on the most prevalent factors they believe to impact the rates of IPV in their counties include socioeconomic disadvantage, substance use, and trauma-related disorders. Trauma-related disorders are "emotional and behavioral problems that may result from... traumatic and stressful experiences,"⁶⁹ for example, IPV. Trauma-related disorders include post-traumatic stress disorder (PTSD), acute stress disorder (ASD) and adjustment disorders,⁷⁰ to name a few. Other factors noted included neighborhoods or areas with high unemployment, poverty, or violence. Populations considered to be at-risk by key informants included adolescents and young adults, Latinx persons, women of color, LGBTQ+ persons, immigrants, non-native English speakers, low-income families and single mothers.

From a prevention perspective, key informants proposed the following solutions. The first includes cross-collaboration participation among different organizations, counties, or municipalities. Partnerships within and across communities can help provide comprehensive care and approaches toward the same goal of health in all communities.

Key informants also suggested the importance of strengthening relationships between domestic violence organizations and law enforcement. While law enforcement has historically been a key response stakeholder

69 Barnhill, J.W. (2020). Overview of Trauma- and Stressor-Related Disorders. Merck: Kenilworth, NJ. Retrieved from <https://www.merckmanuals.com/professional/psychiatric-disorders/anxiety-and-stressor-related-disorders/overview-of-trauma-and-stressor-related-disorders>.

70 Children's Hospital of Philadelphia (n.d.). Adjustment disorders. Retrieved from <https://www.chop.edu/conditions-diseases/adjustment-disorders>.

in the movement, it is also important to note that the police are not always a safe or trusted option, particularly for communities of color.

Finally, several key informants expressed the need for increased resources to be able to adequately provide prevention. Resources specifically mentioned include programming to match diverse populations, the ability to evaluate prevention programming and more funding support for prevention efforts.

Fayette County specifically mentioned their struggle to fully and equitably reach all members of rural communities. Barriers include lack of transportation and poor internet and phone coverage. These barriers will be discussed further in Section B.

Section B - Four Counties, Rural Only

Table 4 shows the four rural Pennsylvania counties with the highest overlap in indicators of risk factors for IPV. The table below indicates the prevalence of risk factors for each county.

Table 4

County		McKean	Cameron	Forest	Potter	Other*
Risk Factor	Indicator	# or Percent				
Support and Cohesion	Social association rate	20.3%	27.8%	13.7%	21.9%	27.8%
	Violent crime rate (# per 100k population)	287.8	126.4	468.5	221.8	66.9
	Food environment index	8.2	8.0	8.0	7.8	8.9
Poverty	Percent of population in poverty	17.3%	14.4%	14.1%	14.4%	6.1%
	Percent of children in poverty	24.9%	23.4%	34.4%	27.8%	6.5%
Unemployment	Unemployment rate	6.2%	6.9%	6.7%	6.6%	3.6%
Economic Opportunities	Income inequality ratio	4.2	4.1	3.1	4.3	3.1
	Severe housing problems	11.4%	9.4%	9.4%	12.0%	7.5%
	Median household income	\$45,031	\$41,335	\$40,564	\$41,309	\$96,803
Alcohol Outlet Density	Excessive drinking rates	20.9%	17.9%	20.9%	18.3%	17.6%
	Alcohol-impaired driving deaths	37.5%	40.0%	9.1%	27.3%	9.1%
	Drug overdose mortality rate	20.7%	No data	No data	21.7%	8.9%

The county **most at risk** for each risk factor by indicator *has been highlighted.*

*In order to show magnitude for these counties in relation to others in the state, the county with the lowest at-risk indicator has been included in the "Other" column.

All of these counties are clustered in northern, mostly north central, Pennsylvania and are adjacent to one another. McKean, Potter and Cameron Counties are clustered together. The violent crime rate is high among each of these counties and in Forest county, is higher than all of the counties included in Section A. It should be noted that Forest County is home to a state prison and this population is included in the rates of each indicator for that county. This should be considered when taking into account the higher rates of risk factors present in Forest County. The poverty rates in this table are more than double the state average in Pennsylvania; no county experiences less than quadruple the state average for percentage of children in poverty. Unemployment rates are double the state average for all counties and equal to, if not higher than, counties in Section A. The median household income is less than half of the state average in each county.

Table 5 illustrates demographics at higher risk for IPV and their representation among each rural county.

Table 5

County		McKean	Cameron	Forest	Potter	PA*
Risk Factor	Indicator	# or Percent				
Gender	Percent of women	48.5%	50.0%	31.5%	50.0%	51.0%
Race	Percent African-American	2.4%	0.8%	20.3%	0.5%	10.8%
Ethnicity	Percent Hispanic (not African-American)	2.2%	1.2%	6.4%	1.4%	7.3%
Age	Percent 18 years old or younger	19.8%	17.7%	9.7%	20.6%	20.8%
Education Level	Percent high school diploma	90%	90%	90%	87%	87%
Household	Percent single parent household with children	42%	49%	31%	30%	34%
Same Sex	Number per 1,000 households	3.05	3.02	0.24	1.54	4.4

*The statewide average for each demographic has been included in the "PA" column.

Counties with **higher than state averages** have been highlighted.

HPW also interviewed stakeholders from each of the four counties to identify any additional factors they feel impact IPV or barriers and see if there are any differences for rural communities. A detailed list of community health problems described by each stakeholder can be found in HPW's full report.

Interestingly, rural stakeholders identified the same major factors as the more-urban counties from Section A of socioeconomic disadvantage, substance use, and trauma-related disorders. Stakeholders also mentioned risk factors unique to rural counties, including community and family stigma around domestic violence, its existence, and how to handle abusive relationships. Though these communities tend to be smaller, they are spread out across vast expanses of land. With minimal public transportation and poor internet and phone connection, stakeholders cite an ongoing lack of ability to access or provide resources to every person in the county. Populations considered to be at-risk by key informants included women, low-income persons, people who are homeless, LGBTQ+ persons, non-native English speakers, and people of faith, including the Amish population.

Rural county key informants also proposed solutions to overcome barriers to achieving safe and healthy communities. Three main themes emerged. The first theme is similar to the idea of cross-collaboration participation among different organizations, counties, or municipalities in Section A. Specific organizations mentioned include behavioral and mental health providers, faith communities, and substance use providers. What is unique about this solution for rural counties is, in addition to working across professional thresholds, there is also a need to work across different communities within the county. Key informants described some communities as "closed off" where "everyone knows everyone," which they feel makes it harder for people to reach out for help and vice versa.

This reality plays a role in the second theme of outreach and education focused on reaching families, with an emphasis on confidentiality. Key informants describe families in rural communities as sometimes the only available resource to a victim or survivor. Outreach and raising awareness of resources may help victims and survivors more readily identify and be able to access help. Stressing confidentiality was proposed to alleviate concerns of reporting because of the "everyone knows everyone" attitude.

The third major theme, again similar to Section A, is the need for increased, accessible resources to adequately provide prevention. The current resources in rural communities are not enough; and a lack of transportation, traditional 9am to 5pm office hours, and barriers to health insurance prevents people from using them. Rural communities need solutions for ways to overcome the barriers of accessing resources.

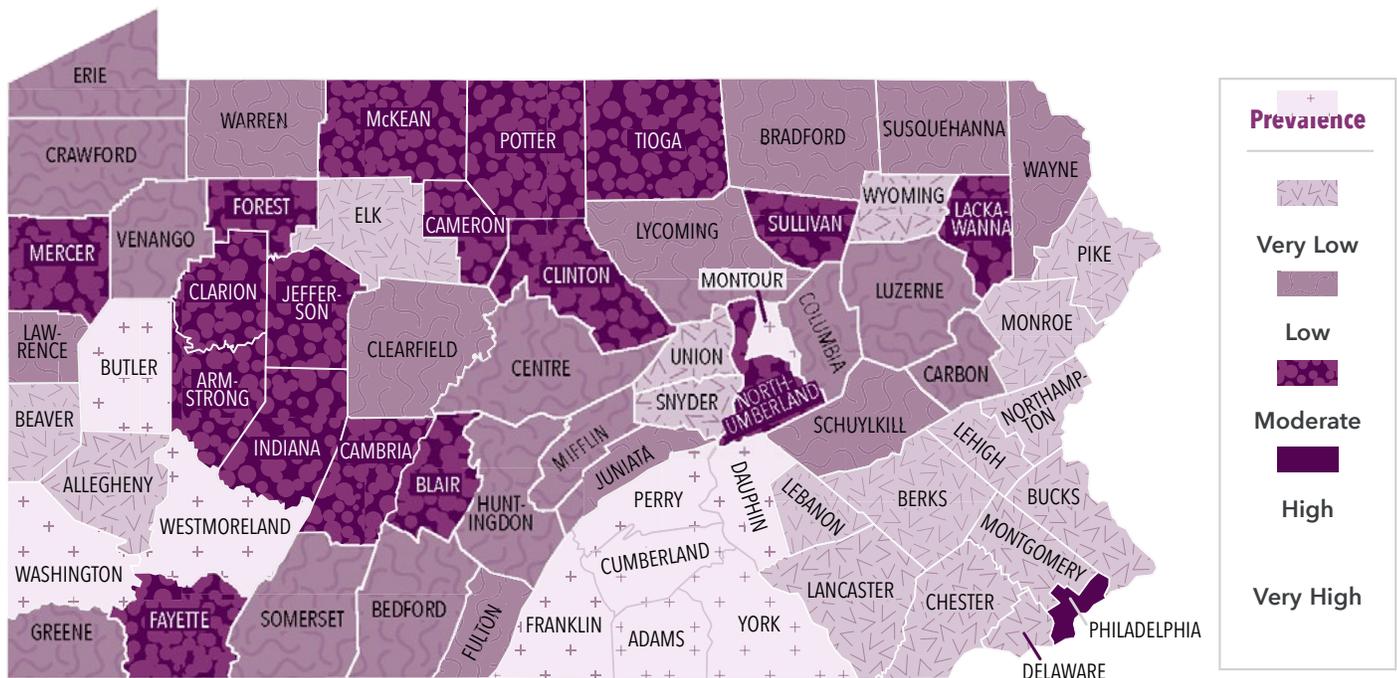
Section C - Statewide Results

Ten counties are reviewed in-depth by this report, but there remain 57 additional counties unaccounted for in the detailed qualitative or quantitative report. This does not indicate that PCADV will not focus prevention efforts in these other counties. For a statewide approach to be effective, all communities within the Commonwealth need to be included. Additionally, because IPV cannot be measured directly in each of the counties, it must be assumed that there is some level of prevalence in each of the counties, and action must be taken toward prevention.

However, HPW did compile a map that illustrates the prevalence of each community-level risk factor for all 67 counties in Pennsylvania. What the map illustrates that cannot be seen in the tables or interviews, is patterns of risk across the state. For example, the high risk of substance use in western Pennsylvania also exists along the eastern region. Diminished economic opportunities and poverty and unemployment are high in rural counties, particularly the northwest and north-central regions of the state. The county of Philadelphia is at high-risk in all categories besides substance use.

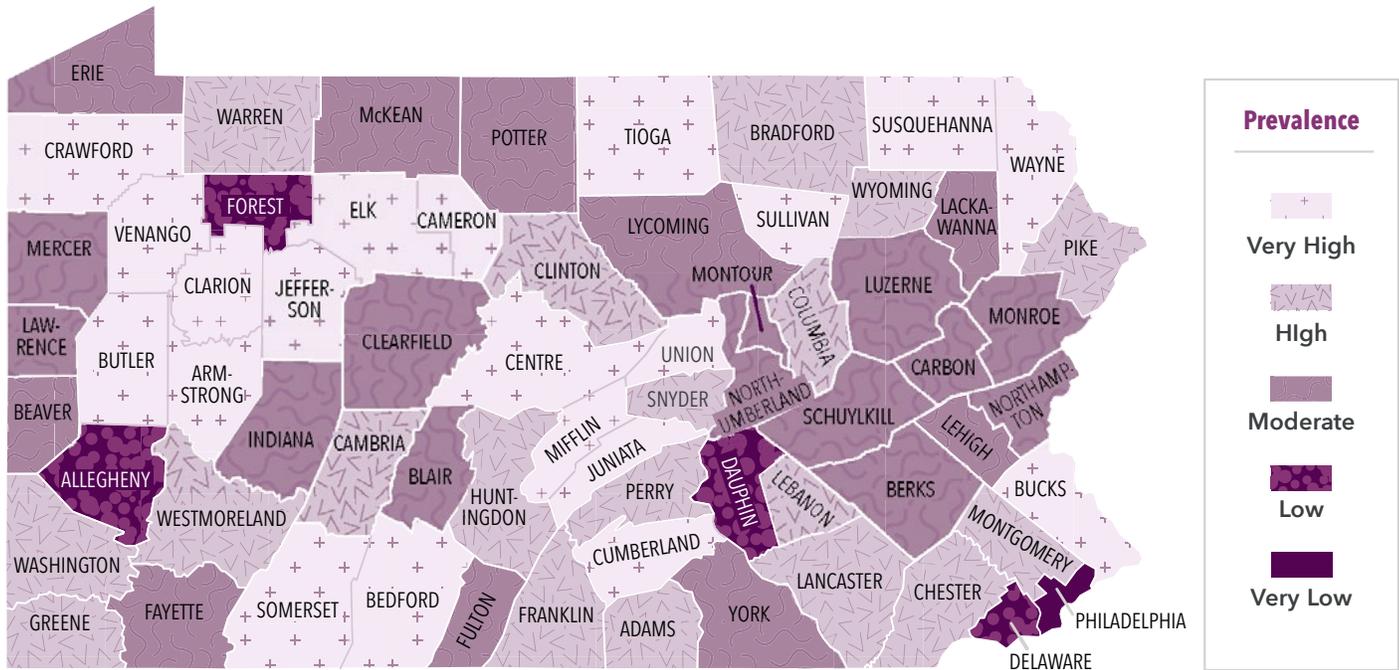
Prevalence of Community-Level Risk Factors for Intimate Partner Violence (IPV) Across Pennsylvania

DIMINISHED ECONOMIC OPPORTUNITIES



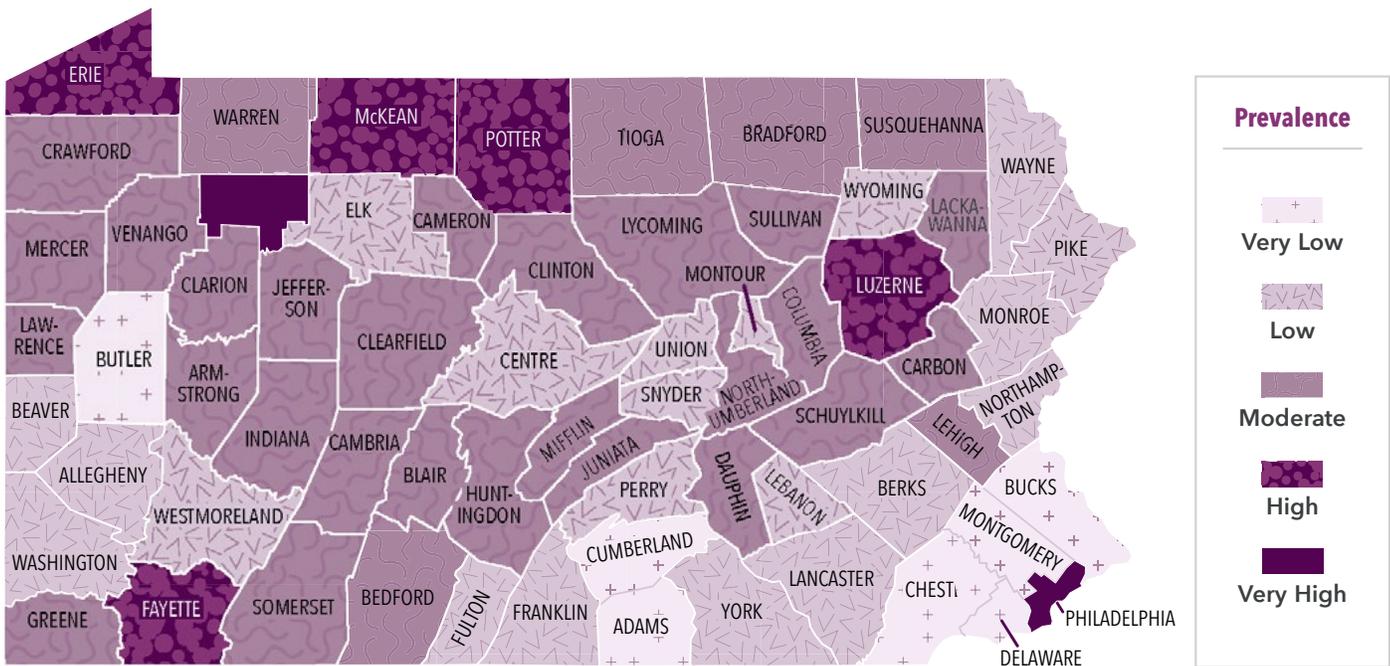
Indicators used to calculate Diminished Economic Opportunities include median household income, severe housing problems, and income inequality ratio. This risk factor is prevalent across much of the state but heavily concentrated in counties in the southwestern and northern regions, and in Philadelphia County specifically.

SOCIAL COHESION



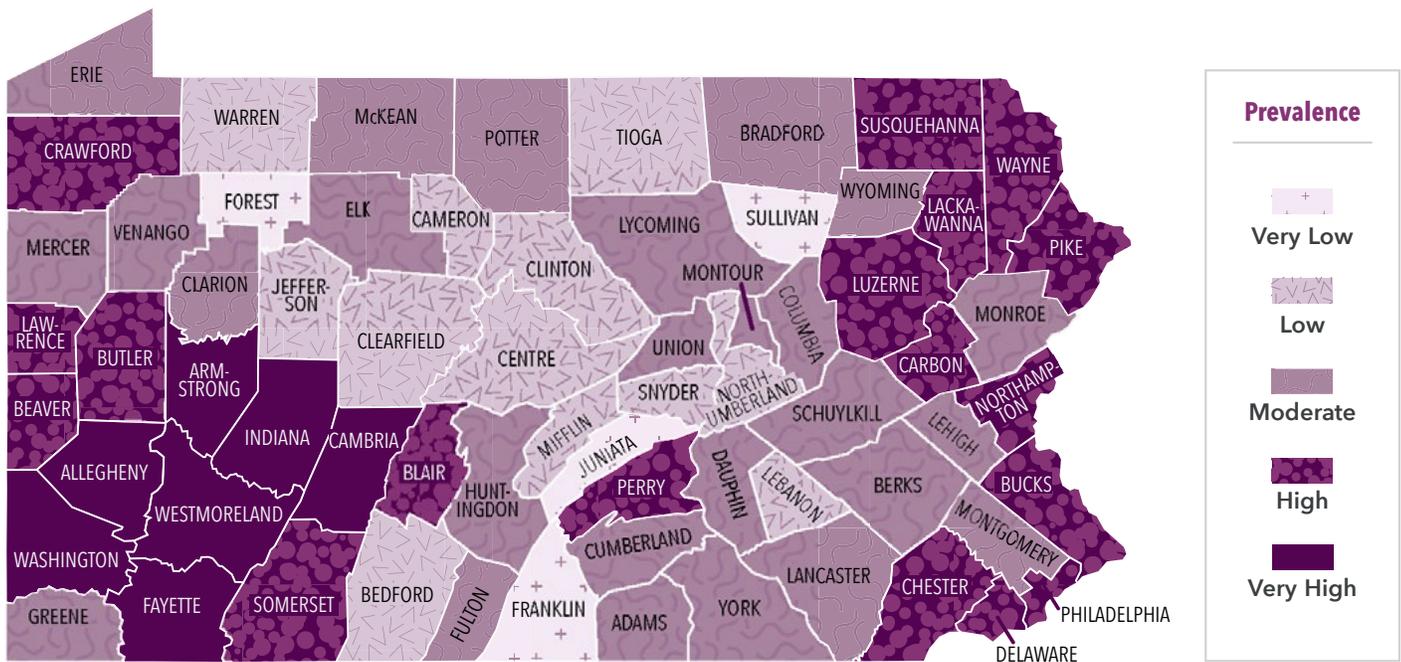
Indicators used to calculate Social Cohesion include the social association rate, violent crime rate, and food environment index. Social cohesion is ranked differently from the other risk factors—“very high” social cohesion is better than “very low” social cohesion. In this way, measuring social cohesion is different than for other indicators. Social cohesion is high across most of the state. Philadelphia county has the lowest social cohesion.

POVERTY AND UNEMPLOYMENT



Indicators used to calculate Poverty and Unemployment include the poverty rate, the rate of children in poverty, and the unemployment rate. This risk factor is “moderate” across most of the state, and “very high” in Philadelphia and Forest counties.

SUBSTANCE USE



Indicators used to calculate Substance Use include excessive drinking rate, alcohol-impaired driving deaths, and drug overdose mortality rate. This risk factor is prevalent on both the eastern and western sides of the state and is most concentrated across the Southwest region.

Prevalence measures for each risk factor ("Very low" to "Very high") were determined through an aggregated score using associated indicators. These scores were broken into five categories based on the prevalence of the indicators and tuned into the ordinal categories reflected in the legends for visual comparison.

Limitations

It should be noted, as in the Dauphin county case study, the prevalence of community-level risk factors is challenging to measure equally across counties. Multiple indicators can be used for different risk factors, and those indicators are not measured in each county, nor are they all publicly available.

Additionally, several Pennsylvania counties are a mixture of rural, urban, and suburban geography and therefore cannot be wholly considered either rural or non-rural.

LESSONS LEARNED

Of all the lessons learned from the needs assessment, perhaps the most significant is that more research is needed to understand better the prevalence, risk factors, and prevention of IPV. In Pennsylvania, there are no current or regularly measured prevalence rates of IPV. Data that do exist on indicators for risk factors can sometimes be inconsistent and are dependent on who is represented in the outreach and questions. Rural communities and LGBTQ+ relationships are frequently underrepresented in the research of known risk factors for IPV. For example, several studies that identify risk factors of IPV only studied heterosexual relationships where the male was the abuser. HPW also points out disparities in research representation among the Latinx community and for persons experiencing non-physical forms of abuse. Each of these populations would benefit from an increased focus in future research of IPV prevalence and risk factors.

Pennsylvania, as a whole, seems to experience more diminished economic opportunities, including below-average median household income, severe housing problems, and the income inequality ratio. Substance use is also significant, particularly in southwestern Pennsylvania. Similar to available data, key informants of all ten counties studied for this report identified socioeconomic disadvantage and substance abuse as issues they feel are connected to rates of IPV in their communities.

In addition to the report, PCADV sought input from its Statewide Leadership Team as well as executive directors and prevention staff from its local member domestic violence programs. Based on what was learned from the report and their own professional experience, PCADV asked the following questions:



WHO should we focus on?

Which populations or demographics are most at risk?



WHERE should we focus?

Which geographic regions are most at risk?



WHAT should we focus on?

Which risk factors, indicators and barriers seem most prevalent?



WHAT ELSE do we still need to know?

Where is our research lacking? What do we need more information about?



WHO should we focus on?

Women

Women of color*

LGBTQ+ communities*

Children and adolescents

Parents

Latinx communities

Single-parent households

Elders

People with disabilities

People who are experiencing homelessness

Faith communities



WHERE should we focus?

Rural*

Mining/coal regions

Urban Areas



WHAT should we focus on?

Economic factors and support*

- High unemployment
- Low economic stability

Alcohol and substance use and accessibility

Stigma around experiencing abuse

Access to services

Community connectedness

School and community climate

Community organizing and empowerment



WHAT ELSE do we still need or need to know?

What is the impact of community-level risk factors on the populations we identified?

How can we access some of the more isolated communities?

How can we achieve true collaboration with other community service organizations?

We need the increased evaluation of existing prevention programs to identify what works.

We need increased resources and sustainable funding to support local domestic violence programs to engage their communities in prevention.

**These topics were noted as areas of focus by the Statewide Leadership Team.*

RESOURCE INVENTORY

PCADV compiled a resource inventory to gather known information about prevention funding, programming, partners, and datasets in Pennsylvania. The resource inventory is available upon request. In the resource inventory, there are 15 local programs noted as engaging in community or societal level prevention program, 11 of which are being evaluated. Five consistent funding sources, 19 partners, and 12 datasets were identified as relevant to prevention efforts.

GOALS, OUTCOMES, AND STRATEGIES

This model is a visual representation of the goals and approaches identified by the SLT after the needs assessment was conducted and input was received from local domestic violence member programs. Over the next five years, PCADV and the SLT will work on strengthening and evaluating our approaches toward meeting our mission to prevent and eradicate intimate partner violence in Pennsylvania. All of this work will be conducted through a lens of anti-oppression and intersectionality.

Our goals include:

Approaches	Outcomes				Goals	Impact
	Short-term	Intermediate	Intermediate	Long-term		
Create a collaborative community of support for prevention in PA at state and local levels.	Increase capacity and skills needed to implement prevention at state and local levels.	Increase or improve coordination among and between state and local level partners. Increase number and type of populations and environments reached by prevention efforts.	Increase resources available to provide sustainable prevention work across PA.	PA communities support and have access to local prevention services.	Decrease in systemic and institutional oppressions.	Decrease and prevent IPV in PA.
Measure effectiveness of work and increase data available on IPV and prevention.	Increase knowledge on the connection between IPV and community/ societal risk and protective factors.	Increase the evaluation of current and new prevention efforts.		PA has a strong statewide and local network of professionals who advocate for prevention efforts.	Equal distribution of power and resources.	
Change the climate of PA to be intolerant of violence and inequities.	Improve sharing of information and strategies among current prevention professionals.	Increase and advocate for prevalence research on underserved populations. (i.e. rural, LGBTQ+) Increase public will and stakeholder commitment to prevention (financially, politically, socially).		PA increases support and advocacy policies/ laws that will decrease risk factors for IPV.	Safe, equitable communities for everyone.	

Context: All prevention work will incorporate a lens of anti-oppression and intersectionality.

Approaches Needed to Meet the Goals

Within each of these approaches are several activities PCADV and the SLT will focus on to achieve our chosen outcomes. Across each of the activities, PCADV will increase our focus on rural settings, women of color and LGBTQ+ populations, and economic contributors to IPV. These themes were considerably lacking in IPV prevention research and the evaluation of IPV.

Approach One

Create a collaborative community of support for prevention in Pennsylvania at state and local levels.

Activities:

- Continue offering training and technical assistance to local domestic violence member programs.
- Maintain membership of the Statewide Leadership Team and work toward 5-year goals.
- Strengthen and create state and national partnerships relevant to sharing best practices.
- Work to improve community access to prevention services.
- Develop a database for the networking of Pennsylvania prevention professionals.
- Raise up and support existing, local-level community prevention leaders.

Approach Two

Measure the effectiveness of work and increase data available on IPV and prevention.

Activities:

- Create a data dashboard to measure the community and societal risk and protective factors of IPV.
- Use the prevention database and local program monitoring to track local prevention efforts.
- Evaluate all prevention efforts and help local programs do the same.
- Implement efforts to increase the research and data available on IPV, IPV prevention, and the focus areas.

Approach Three:

Change the climate of Pennsylvania to be intolerant of violence and inequities.

Activities:

- Educate about the state, local, and organizational remedies toward the decrease of IPV and risk factors and the increase of protective factors.
 - Work to raise stakeholder support of efforts to improve pay equity.
 - Continue to run and expand the annual engaging men's campaign while improving the role of men's leadership locally.
 - Pursue prevention initiatives toward changing harmful norms around gender and equality.
-

HOW PCADV WILL EVALUATE THE PLAN

PCADV will evaluate the state action plan throughout the five years. Areas of interest include the process of implementing the state action plan, the outcomes that arise during this period, and the continuous quality improvement internal to the PCADV Prevention Team and SLT. At the end of the five-year state action plan, PCADV and the SLT will produce a summative evaluation document.

Data sources will include internal and secondary public data as it becomes available. For external data, a state-level indicators dashboard will be developed to track long-term community and societal outcomes related to risk and protective factors for IPV. The development of this dashboard will serve as a primary data source for evaluation.

Secondarily, internal records will be kept and updated for evaluating process, implementation, and quality improvement. Internal records that PCADV collects on an annual basis include the Annual Prevention Survey, Annual Prevention Report, and the internal work plan of the prevention team. The creation of a database for local prevention programs will aid in the record-keeping of local efforts and their success.

PCADV's member programs, the SLT, local prevention specialists, and PCADV's internal team will be provided with annual updates on the progress to the plan.



SUSTAINABILITY PLAN

The sustainability of this plan and the efforts it contains depends on the strength of the framework PCADV is able to build in the areas of public support, funding, and policies.

Public support of prevention is needed to bring efforts to local communities and direct funding. PCADV will increase public support through awareness-raising, education, and building partnerships with institutions that affect IPV risk factors.

Changing social norms and policies takes years of consistent work, which is why regular and adequate funding is necessary to maintain prevention initiatives. PCADV will continue to seek funding to prioritize prevention efforts at a feasible and sustainable level.

As mentioned previously, changing policies is a long-term outcome toward achieving sustainable change. Policies can be unique to companies and organizations, or larger to communities, states, and the federal government. Success in policy work can change norms in schools, improve funding for prevention, or increase the data available on IPV. PCADV will collaborate more closely between prevention and policy efforts and will work to have pay equity included as a policy priority.

PREVENTION AS A CAREER PATH

The prevention of IPV and the consideration of violence as a public health issue did not gain traction until 42 years ago.⁷¹ The CDC dedicated a division to violence prevention in 1993.⁷² The first state domestic violence coalitions began working on violence prevention with funding from the CDC in 2002.⁷³ All told, the prevention of IPV as a field of study and a career is relatively young. While there is funding available toward prevention efforts, there does not exist, federally, designated, non-transferable funding for the prevention of IPV; which can lead to funding priorities shifting in times of crisis or underfunding, which often leaves out or moves money away from prevention.

Funding that does cover prevention and prevention-related activities is often limited. Meaning, there is often a strong push from funders for quantity over quality. This may force a local program to dilute their prevention efforts to meet expectations. This quantity over quality approach is not proven to have an effective, sustainable impact on changing the attitudes or behaviors of participants.

Similarly, there is minimal education provided for the prevention of IPV in secondary institutions. While fields of public health and health promotion may focus on prevention and fields of human services and social sciences may focus on violence, there are not many programs focused on the intersection of the two, particularly of intimate partner violence. This creates an on-boarding gap for IPV prevention; because there are few people entering the field with an understanding of prevention, let alone, IPV, it takes this field significantly longer to train staff. On lesser paid positions with minimal room for growth, the length of training time can be a barrier. At the other end of the spectrum, less representation in higher academic spaces leads to less representation – or misrepresentation – of IPV and IPV prevention in research.

The prevention of IPV as a job can be carried out at the entry-level in a number of settings, with a local domestic violence program, at a community or sports organization, with a college or university, or at a hospital, to name a few. As a specialist moves up in the career of IPV prevention, their options become limited. Typically, these options include senior positions within their current organizations or work with state, territory, or national domestic violence coalitions. Advancing in a prevention career, there become fewer opportunities for the education, positions, and salary to match their expertise.

Preventing IPV depends on the expertise and existence of prevention specialists as much as the infrastructure of funding, policies and education necessary to make prevention a sustainable field of work. This state action plan hopes to prevent IPV in Pennsylvania and also strengthen the field of IPV prevention as a legitimate and necessary career.

71 HHS & CDC, History of Violence as a Public Health Issue.

72 Ibid.

73 Ibid.

In closing, PCADV would like to thank our local membership programs and our Statewide Leadership Team for their tireless advocacy for victims and survivors of intimate partner violence in Pennsylvania. It is because of their work that we are able to dream big, for safe and healthy relationships and communities for all who reside in Pennsylvania.

STATEWIDE LEADERSHIP TEAM

AccessMatters

Melissa Weiler Gerber*

The Center for Rural Pennsylvania

Christine Caldara Piatos
Mary Kandray Gelenser

Center for Safe Schools

Leah Galkowski

Domestic Abuse Project of Delaware County

Nicole Powell, MSW*

Domestic Violence Center of Chester County

Dr. Dolly Wideman-Scott, Ed.D.
Amelia Rayburn-Pizzica
Joe Henson

First National Bank

Greg Conrad

Governor's Advisory Commission on Asian Pacific American Affairs

Dr. Vasu Singh, MD

Jewish Family Service of Harrisburg

Barry Stein, MSW, ACSW, MPA
Steven Schauder, MSW, CFRE*

PA Families, Inc.

Maggie Parke

Penn State University

Candelyn B. Rade, PhD

Penn State University, Edna Bennet Pierce Research Center, EPIS

Meghan Lynne Blevins*

Pennsylvania Coalition Against Domestic Violence

Kristen Herman, MPH
Nick Silveri-Hiller
Genevieve Hugenbruch
Aishwarya Sinha

Pennsylvania Coalition Against Rape

Jackie Strohm, LSW
Ashton Whitmoyer-Ober

Pennsylvania Commission on Crime and Delinquency

Jeffrey A. Blystone

Pennsylvania Human Relations Commission

Guerline L. Laurore, Esq.*
Taiwan Martinez, MA, M.S.Ed.*

Pennsylvania State Data Center

Susan D. Copella

Pennsylvania Department of Banking and Securities

George Hindson, CGFM

Pennsylvania Immigrant and Refugee Women's Network

Mary Daman
Maria Alejandra Hernandez*

Safe Schools Office, Pennsylvania Department of Education

Pam Emery, PhD*
Joe Loccisano, PhD*

Susquehanna University

Christiana Paradis, MSW

Trans Advocacy Pennsylvania

Joanne M. Carroll

Soul Requirements (previously with the Women of Color Network)

Zöe Flowers

Women's Center of Columbia and Montour Counties

Marissa Holshue
Ciarra Yoder

Woman's Way

Diane Cornman-Levy
Camille Nickow

* Team members met for two years to author this state action plan. An asterisk (*) indicates new members to the team since the development of the plan. Interested in learning more about the team and how to get involved? Please contact Kristen Herman at kherman@pcadv.org.

PCADV LOCAL PROGRAMS

PCADV has a statewide network of direct-service, local domestic violence programs that are ready to help.

ADAMS COUNTY

Safe Home / YWCA Hanover

ALLEGHENY COUNTY

Center for Victims
Crisis Center North, Inc.
Women's Center & Shelter of
Greater Pittsburgh
Alle-Kiski Area HOPE Center, Inc.

ARMSTRONG COUNTY

HAVIN, Inc.

BEAVER COUNTY

Women's Center of Beaver County

BEDFORD COUNTY

Your Safe Haven, Inc.

BERKS COUNTY

Safe Berks

BLAIR COUNTY

Victim Services of Family Services, Inc.

BRADFORD COUNTY

Abuse & Rape Crisis Center

BUCKS COUNTY

A Woman's Place

BUTLER COUNTY

Victim Outreach Intervention Center

CAMBRIA AND SOMERSET COUNTIES

Women's Help Center, Inc.

CENTRE COUNTY

Centre County Women's
Resource Center

CHESTER COUNTY

Domestic Violence Center of
Chester County

CLARION COUNTY

SAFE (Stop Abuse for Everyone), Inc.

CLINTON COUNTY

Clinton County Women's Center

COLUMBIA AND MONTOUR COUNTIES

The Women's Center, Inc. of
Columbia/Montour

CRAWFORD COUNTY

Women's Services, Inc.

CUMBERLAND AND PERRY COUNTIES

Domestic Violence Services of
Cumberland & Perry Counties

DAUPHIN COUNTY

YWCA of Greater Harrisburg Violence
Intervention & Prevention Services

DELAWARE COUNTY

Domestic Abuse Project of
Delaware County, Inc.

ELK AND CAMERON COUNTIES

C.A.P.S.E.A., Inc.

ERIE COUNTY

Safe Journey
SafeNet Domestic Violence
Safety Network

FRANKLIN AND FULTON COUNTIES

Women In Need, Inc.

FOREST AND WARREN COUNTIES

A Safe Place, Inc.

HUNTINGDON COUNTY

Huntingdon House

INDIANA COUNTY

Alice Paul House

JEFFERSON AND CLEARFIELD COUNTIES

Community Action, Inc./
Crossroads Project

LACKAWANNA AND SUSQUEHANNA COUNTIES

Women's Resource Center, Inc.

LANCASTER COUNTY

Domestic Violence Services of Lancaster
County

LAWRENCE COUNTY

Crisis Shelter of Lawrence County

LEBANON COUNTY

Domestic Violence Intervention
of Lebanon County, Inc.

LEHIGH AND NORTHAMPTON COUNTIES

Turning Point of Lehigh Valley, Inc.

LUZERNE AND CARBON COUNTIES

Domestic Violence Service Center, Inc

LYCOMING COUNTY

YWCA NorthCentral PA Wise Options

MCKEAN COUNTY

YWCA Bradford Victims' Resource Center

MERCER COUNTY

AWARE, Inc.

MIFFLIN AND JUNIATA COUNTIES

The Abuse Network

MONROE COUNTY

Women's Resources of
Monroe County, Inc.

MONTGOMERY COUNTY

Women's Center of Montgomery County
Laurel House

PHILADELPHIA COUNTY

Congreso De Latinos Unidos, Inc
Lutheran Settlement House
Women Against Abuse, Inc.
Women In Transition

POTTER COUNTY

A Way Out

SCHUYLKILL COUNTY

Schuylkill Women in Crisis

SULLIVAN COUNTY

Sullivan County Victim Services

TIOGA COUNTY

HAVEN of Tioga County, Inc.

UNION, SNYDER, AND NORTHUMBERLAND COUNTIES

Transitions of PA

VENANGO COUNTY

PPC Violence Free Network

WASHINGTON, GREENE AND FAYETTE COUNTIES

Domestic Violence Services of
Southwestern PA

WAYNE COUNTY

Victims' Intervention Program

WESTMORELAND COUNTY

Blackburn Center

WYOMING COUNTY

Victims Resource Center

YORK COUNTY

YWCA York/ACCESS



National Domestic Violence Hotline: 1.800.779.7233
National Teen Dating Violence Hotline: 1.866.331.9474

Visit [PCADV.org](https://www.pcadv.org) to find local programs
by location and services offered.