Putting Ourselves Out of Business: A Feminist Approach to Integrating Prevention as a Core Operating Principle for Intimate Partner Violence Service Agencies

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Intimate partner violence (IPV) is a serious public health crisis affecting one in every three U.S. women according to the Centers for Disease Control and Prevention ([CDC], 2011).[1] But IPV is more than a public health issue; it is a social justice crisis and must be understood as a manifestation of patriarchal oppression. Women are disproportionately vulnerable to IPV victimization, a phenomenon which enforces the notion that women are a subordinate class subject to male control.[2] Because IPV represents a public health and social justice crisis, these are precisely the kinds of responses which are required if IPV is to be prevented.[3]

Parks, Cohen, and Kravitz-Wirtz (2007) contend that we are at the precipice of a new stage in the movement to end IPV marked by "a greater emphasis on and expanded notion of prevention," defining prevention as "a systematic process that promotes safe and healthy environments and behaviors, reducing the likelihood or

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[1] The CDC defines IPV as physical violence, rape, and/or stalking by a current or former intimate partner. Physical violence includes, "a wide range of behaviors from slapping, pushing or shoving to more severe behaviors such as being beaten, burned, or choked" (p. 10). Rape includes, "completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration" (p. 2). Stalking includes, "a pattern of unwanted harassing or threatening tactics used by a perpetrator including tactics related to unwanted contacts, unwanted tracking and following, intrusion, and technology-assisted tactics" (p. 10).Victims of IPV experience a host of health-related consequences including injury, post-traumatic stress disorder, asthma, high blood pressure, frequent headaches, chronic pain, insomnia, diabetes, activity limitations, and overall poor health.

[2] The Bureau of Justice Statistics (2009) found that women represent four out of every five IPV victims and that nearly half (forty five percent) of female homicide victims are killed by an intimate partner. Wathen and MacMillan (2011) found women suffer greater physical and emotional harm than do male victims. The Duluth Project (2005) found that the dynamics of IPV mimic the structure of patriarchal oppression on the micro level, constituted by a pattern of male domination over female partners.

[3] To suggest that IPV is a public health *and* social justice crisis certainly does not mean that these two ways of understanding the problem are mutually exclusive or in conflict. This paper will discuss the interrelationship between health- and justice-oriented approaches to IPV prevention in the section on health equity.

frequency of an incident, injury, or condition occurring" (p. v, 1). This movement is sustained at the ground level by community-based IPV agencies which serve individual survivors and their families. This paper takes a feminist approach to investigating the relationship of IPV service agencies to prevention, exploring what it would mean for these agencies to operate with prevention as a core principle and what benefits this approach might offer.

As an IPV service practitioner, I have countless times heard the claim that, "we are working to put ourselves out of business," a claim which proves specious when one considers how IPV agencies generally operate relative to prevention.[4] In the last decade, these agencies have increasingly focused on building capacity for prevention at the local level; however, they have often done so in ways which limit their full preventive potential. That is, in building capacity for prevention, IPV service agencies tend to add onto rather than transform the work they do, siloing prevention away from the direct-service work the heart of their operations (Robert Wood Johnson Foundation [RWJF], 2013). IPV agencies might create individual prevention-based positions or departments, but generally do not consider how their existing structures might be oriented toward prevention.

When prevention is a supplemental, often diminutive function of IPV service agencies, it certainly does not represent that which they are in the business of

[4] The author has worked as a community educator, trainer, supervisor, crisis line operator, front desk advocate, and hospital advocate for the past seven years at The Center for Women and Families, focusing the bulk of my work on training other professionals to recognize and respond to IPV. I feel it is important to state the position from which I approach this research in order to demonstrate my interest and stake in integrating prevention in IPV agencies and as a way of situating my perspective. I am critical of IPV service agencies as an IPV service provider myself.

doing. For IPV practitioners to make good on the claim that ending violence is our mission, we must find ways to integrate prevention as a core operating principle, with a commitment to significant transformation of the work. IPV agencies need not sacrifice direct service to survivors in order to do this. While integrating prevention requires fundamental changes to the service provision model, transformation can be accomplished by beginning with direct service and discovering ways to orient that service toward preventive efficacy. There are already promising models for how this might be done available in other public health and social justice fields, including HIV/AIDS and sexual violence prevention. Furthermore, in a climate of limited resources, agencies would be well served to integrate prevention into their direct service operations rather than sustaining what are essentially ancillary programs (National Network to End Domestic Violence, 2013).

In order to make the case for integrating prevention as a core operating principle of IPV agencies, this paper will investigate literature on prevention and service provision, uncovering and discussing ways these agencies might transform their work. The paper will review literature on IPV dynamics in order to understand their social implications for prevention and position the problem as an issue of feminist concern. The paper will then review literature on the history of IPV agencies in order to identify salient developments that explain their current positions relative to prevention and to make the case for integration. The paper will go on to review proven and promising approaches to prevention in the domains of public health and social justice, explaining overlaps, convergences, and areas for

possible integration, drawing on lessons learned from other movements. The paper will make recommendations for using a feminist approach to transform the work of IPV service agencies by integrating prevention as a core operating principle for service provision. The paper will use one agency, The Center for Women and Families (CWF) in Louisville, Kentucky as a case example for how this might be done.[5]

UNDERSTANDING INTIMATE PARTNER VIOLENCE

For the purposes of qualifying IPV as an issue of feminist concern and to justify a feminist approach to integrating prevention, I will use bell hooks' (1984) definition for feminism. Hooks defines feminism as "a movement to end sexist oppression" and qualifies oppression as "the ideology of domination" (17, 24). For hooks, feminist concern must address not only gender but also race and class because sexist oppression is intrinsically connected with class and racial/ethnic oppression. Using this definition, IPV can be positioned as an issue of feminist concern because it is a micro-level manifestation of the macro-level ideology of domination. We can see this by attending to three central facts about IPV: women represent the vast majority of IPV victims while the vast majority of perpetrators are male; women marginalized by race/ethnicity, class, disability, and gender identity are at increased risk for IPV; and abusive relationships per se are microcosms of patriarchal domination.

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[5] CWF provides services for survivors of both IPV and sexual violence. However, there is a significant amount of work available on integrating prevention within sexual violence service agencies and a dearth of such work relative to IPV. Therefore, this paper will focus on the IPV services of the agency, although many of the findings and recommendations could be applied to the agency's sexual violence services as well.

According to BJS (2009), women represent four of every five victims of IPV while ninety six percent of perpetrators are male. In 2012, the CDC found that women of color are disproportionately vulnerable to IPV. Four in ten non-Hispanic Black, American Indian, and Alaska Native women as well as nearly half of multiracial non-Hispanic women had experienced IPV in their lifetimes. While the CDC collected only age, race/ethnicity, and gender information in its demographics, other literature indicates increased vulnerability for women belonging to additional, socially marginalized groups. Courvant and Cook-Daniels (2003) found that approximately half of Trans women they surveyed had experienced IPV in their lifetimes. In 2009, BJS also found that women with disabilities were at increased risk for IPV when compared with women without disabilities. Sokoloff and Dupont (2005) found that low-income women were also disproportionately at risk for experiencing IPV and that individuals with multiple, intersecting oppressed identities face not only a higher risk for victimization, but also a greater severity of violence and lethality.

When one applies a feminist analysis to IPV dynamics, it becomes clear that this increased vulnerability among oppressed women is not merely coincidental. The Duluth Project (2005), which pioneered research and intervention strategies for IPV early in the battered women's shelter movement, defines IPV as a "pattern of actions that an individual uses to intentionally control or dominate his intimate partner" (para. 5). The Duluth Project created the power and control wheel to qualify what count as these kinds of actions (see appendix). The wheel divides IPV

into nine primary categories: physical/sexual violence, intimidation, emotional abuse, isolation, minimizing/denying/blaming, using children, using male privilege, economic abuse, and coercion/threats. These forms of power and control are relationship-level expressions of the ideology of domination that characterizes sexist oppression and makes socially marginalized women more vulnerable to exploitation.

IPV perpetration is clearly a relationship-level mechanism of gendered control. Dobash and Dobash (1992) found that the primary impetuses for conflict leading men to physically assault their partners were "men's possessiveness and jealousy, men's expectations concerning women's domestic work, men's sense of the right to punish 'their' women for perceived wrongdoing, and the importance to men of maintaining or exercising their position of authority" (p. 4). IPV is simultaneously evidence and means of reinforcing male dominance over women. In this way, IPV represents a form of structural violence as conceived by Gil (1996) because it involves, "domination of some individuals and groups by others for social and economic gain" (p. 77). As a form of structural violence, IPV is inherently a social justice concern. Structural violence, according to Gil, is characterized by inequality, exploitation, selfishness, competition, and disregard for community, all of which are constitutive elements of IPV. As a form of structural violence, IPV prevention cannot rest on individual interventions but rather must address macro-level inequalities (by gender, race, class, and ability) that sanction violence against women. While IPV agencies originated as an arm of the mid-twentieth century feminist movement, today these agencies generally fail to adequately address social

systems of power, focusing instead in individual service (White, 2006). We must consider how IPV agencies came to develop this level of focus and why they are now best positioned for prevention integration in the interest of putting themselves out of business.

A BRIEF HISTORY OF IPV AGENCIES AND PREVENTION

IPV, as a reified concept, emerged from consciousness raising efforts of the U.S. feminist movement in the late 1960s. In response to uncovering the pervasion of this problem in women's lives, feminist advocates began to organize services for IPV victims, initiating what became a growing movement for battered women's shelters in the early 1970s. From the inception of this movement, advocates were concerned with not only helping victims, but also ultimately stemming the tide of IPV perpetration in the U.S. (Schecter 1984). In its nascence and growth, this movement and the associated shelters focused on direct-service and awareness/consciousness raising as their primary means of prevention, taking a social justice approach by framing IPV as an issue of women's oppression (Kulkarni, Bell, Rhodes, 2012; Cohen, Davis, and Graffunder 2006).

However, in the 1980s many IPV agencies and shelters increasingly adopted strategies from a professionalized social work model that prioritized direct services to victims over prevention efforts (White 2006?). The solution to IPV largely became treating victims rather than addressing the root social causes which created and fostered male domination over female partners. As a result, many IPV agencies

were significantly de-radicalized during this time; focus shifted primarily to direct services to victims and interest in prevention waned (White 2006).

During this same period, the public health community began to pay increasing attention to the problem of IPV and the potential for prevention. In 1985, then-Surgeon General C. Everett Koop organized a conference on violence in the U.S., where for the first time, IPV was directly framed as a public health crisis of epidemic proportions (Prothrow-Stith, 2007). Framing IPV as a public health problem renewed interest in prevention among IPV agencies in the 1990s and offered new, evidence-based methodologies for how this might be done. Perhaps no single event more solidly marked the shift toward public health approaches among IPV agencies than the 2002 launch of the CDC's Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) program (VAWnet 2013). The DELTA program sought to increase the capacity of IPV agencies to prevent violence by funding fourteen state-wide coalitions to provide training, technical assistance, and financial support for local IPV service agencies to develop prevention programs (CDC 2010). Developing new programs, however, meant that prevention initiatives were tacked onto existing operations and generally isolated from the direct-service work at the heart of agency missions (Parks et al., 2007; Lyles and Tsao, 2012). The follow-up DELTA Prep program, launched in 2007, engaged 19 more state coalitions and the agencies they support in prevention program development under public health frameworks (CDC 2013a).[6]

[6] DELTA-funded state coalitions include those in Alabama, Alaska, California, Connecticut, Delaware, Florida, Idaho, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Montana,

This history helps us understand the current state of IPV service agencies relative to prevention and why they are now positioned to consider integrating prevention as a core operating principle. In general, over the past few decades IPV agencies have become professional social work enterprises disconnected from a concern with social justice. When a public health approach was applied to these agencies at the end of the twentieth century, most, with their foci on direct services to victims, had already drifted so far afield of their original goal of ending IPV that prevention was irrelevant to the core of their work. Therefore, the promise of prevention offered by the public health community had little to no impact on transforming the general operations of IPV agencies; rather public health was treated as an approach for developing new, add-on programs.

The stakes of preventing IPV are high and given these historical developments, it seems service agencies ought to consider pressing the proverbial reset button – that is, making good on their foundational commitment to end IPV by using social justice and public health frameworks to re-evaluate and re-orient their work with prevention as the core operating principle. (Parks et al., 2007; RWJF, 2013). Let us now to turn literature on these public health approaches as they relate to IPV prevention in order to understand their potential for shaping the basic operations of service agencies.

PUBLIC HEALTH APPROACHES TO PREVENTION

Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, Washington, Washington, DC, and Wisconsin.

Prothrow-Stith (2012) contends that public health frameworks for prevention hold promise for IPV agencies because these frameworks have proven their ability to reduce and eliminate negative social conditions which foster health problems like violence. For Parks et al. (2007), prevention is a "systematic process" and the steps most key for IPV agencies in this process involve identifying the risk and protective factors for violence, appropriately situating these factors in a social ecology, and structuring interventions to prevent violence in primary, secondary, and tertiary ways (p. v).

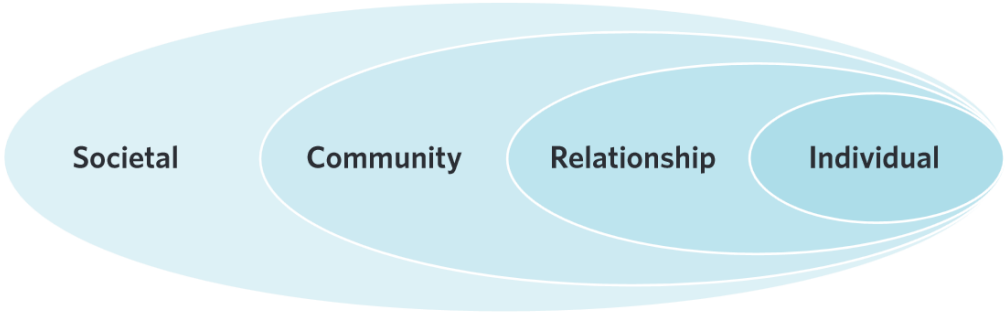
Risk factors are those conditions which increase the likelihood of IPV victimization or perpetration and protective factors are conditions which decrease this likelihood (Stith, Smith, Penn, Ward, and Tritt, 2013).[7] Reducing or eliminating risk factors and creating or bolstering protective factors should decrease rates of IPV (Whitaker, Morrison, Lindquist, Hawkins, O'Neil, Nesius, Mathew, and Reese, 2005).

Risk and protective factors exist across a social ecology comprised of four spheres: individual, relational, communal and societal.[8] The World Health

[7] For many risk and protective factors identified in the literature, there is no direct causal link with IPV. Risk and protective factors are thus understood as correlates rather than causes of IPV.
[8] The WHO defines the scope of these spheres as, "Individual: includes biological and personal history factors that may increase the likelihood that an individual will become a victim or perpetrator of violence. Relationship: includes factors that increase risk as a result of relationships with peers, intimate partners and family members. These are a person's closest social circle and can shape their behaviour and range of experiences. Community: refers to the community contexts in which social relationships are embedded – such as schools, workplaces and neighbourhoods – and seeks to identify the characteristics of these settings that are associated with people becoming victims or perpetrators of intimate partner and sexual violence. Societal: includes the larger, macro-level factors that influence sexual and intimate partner violence such as gender inequality, religious

Organization ([WHO], 2010) uses a concentric design to illustrate that these spheres are successively contained within one another (p. 19). In addressing risk and protective factors, interventions must be designed to match the corresponding sphere in the social ecology. Interventions which address the larger spheres in the social ecology can be expected to have an impact on the smaller spheres contained within them; however, the inverse is not true.

Figure 1



While there is an array of literature identifying IPV risk and protective factors, the bulk of this research focuses on specific communities and contexts and cannot be assumed to hold true in other contexts. For the purposes of making general claims about integrating prevention into IPV agencies, we will use the CDC (2013b) identified risk and protective factors (although further literature on factors identified elsewhere with a similar breadth of scope will be introduced in the discussion on integrating prevention).[9] These factors are:

Individual

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or cultural belief systems, societal norms and economic or social policies that create or sustain gaps and tensions between groups of people" (p. 19).

[9] It is worth noting that while the CDC describes these as risk and protective factors, the factors they identify appear only to involve risk.

- Low self-esteem
- Low income
- Low academic achievement
- Young age
- Aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression
- Anger and hostility
- Antisocial personality traits
- Borderline personality traits
- Prior history of being physically abusive
- Having few friends and being isolated from other people
- Unemployment
- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Desire for power and control in relationships
- Perpetrating psychological aggression
- Being a victim of physical or psychological abuse
- History of experiencing poor parenting as a child
- History of experiencing physical discipline as a child

Relationship

- Marital conflict-fights, tension, and other struggles
- Marital instability-divorces or separations
- Dominance and control of the relationship by one partner over the other
- Economic stress
- Unhealthy family relationships and interactions

Community

- Poverty and associated factors (e.g., overcrowding)
- Low social capital-lack of institutions, relationships, and norms that shape a community's social interactions
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

Society

- Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)

Gullotta and Bloom (2003) offer a further promising, tri-partite prevention model which can help IPV agencies organize their prevention services. Primary interventions seek to prevent a condition before it occurs. Secondary interventions seek to identify and respond to conditions in an immediate way that reduces the likelihood of further victimization and possibly imminent harm. Tertiary interventions seek to prevent or ameliorate the more lasting harms caused by a condition.

These basic public health frameworks shape and contextualize the literature specific to violence prevention. This literature suggests that interventions addressing the highest spheres should be prioritized; but, in practice, interventions tend to target the individual level. Among the 19 DELTA prep sites, the majority of the programs the CDC identifies as exemplary are designed to raise awareness that IPV is a problem and that it should not be tolerated (CDC 2013a). Raising awareness is an individual-level intervention. While intolerance to violence would seem to address the communal level risk factor of weak sanctions, the intervention design targets the individual level and as such cannot be expected to affect a communal-level risk factor. Furthermore, Gil (1996) contends that individual-level interventions imply that acts of violence are discrete events rather than a social problem. He argues that primary prevention should be designed to address the causes rather than the symptoms of this social problem. Parks et al. (2007) similarly contend that as long as IPV is understood as an individual behavior, we can continue to expect individually-oriented prevention strategies. Taken together, these two points suggest a cyclically enforcing and problematic approach to IPV prevention in which individual-level interventions position IPV as an individual-level problem around which further individual-level interventions are designed. Parks et al. (2007) argue that we should instead focus on the social conditions at the root of IPV and that it is implausible to expect individual-level change without changing the social environment. They encourage going beyond the individual level by engaging broad community constituencies in efforts to prevent IPV.

Piran's (2010) feminist approach to public health prevention strategies provides a helpful model for understanding how agencies might orient their work toward the higher levels of the social ecology and integrate prevention into direct service operations. Piran contends that lower-level risk factors for problems disproportionately affecting women and girls should be understood as "epiphenomena" of sexist oppression; that is, lower level risk factors for IPV are created and maintained by sexist power structures at the societal level (p. 187). Piran's approach is particularly helpful when applied to the public health literature on IPV prevention because traditional gender norms are the only societal-level risk factor identified by the CDC. Integrating prevention as a core operating principle thus means adopting a feminist approach to the work which positions individual, relational, and communal-level risk factors as manifestations of sexist oppression. Furthermore, Piran's approach is helpful in understanding how risk factors are compounded in the lives of women most at risk for IPV by connecting these risk factors as interrelated elements of sexist oppression. Piran's model is comprised of five methods for feminist prevention work: targeting prevention toward the social environment, engaging participants in critical dialogue, linking risk factors in a gendered framework, making interventions context-specific, and positioning participants as agents of social change.

INTEGRATING PREVENTION ACROSS THE SOCIAL ECOLOGY: PRIORITIZING AND TARGETING THE COMMUNAL SPHERE

Beginning with Piran's requirement that prevention initiatives be targeted toward the social environment, literature on IPV prevention puts a strong emphasis on community-level interventions, suggesting that this is the level where local agencies will have the greatest impact. In the interest of utility, we will begin discussion of ways to integrate prevention across the social ecology at the community level.[10] Members of the Urban Network to Increase Thriving Youth ([UNITY], 2010) contend that programs should work to increase communal capacity to prevent IPV in the most vulnerable neighborhoods with the goal of transforming community conditions. This begins with meaningful dialogue that involves community members in designing interventions. Parks et al. (2007) suggest engaging community leaders as partners in planning and implementing interventions while Aboelata, Ersoylu, Cohen, and Swartz (2011) argue that all members in a given community should be invited to meaningfully participate in this process. When interventions successfully mobilize communities around violence prevention, UNITY (2010) argues that residents increase connection with one another and improve individual wellbeing. That is, by reaching the community level, agencies can expect to see an impact on the relational and individual levels of the social ecology. Cohen, Davis, and Graffunder (2006) contend that as long as community norms encourage violence and do not support safe, equitable

[10] Community-based organizations certainly can have an impact in the societal sphere; however, the literature suggests that for IPV, service agencies, the communal sphere is the most auspicious area of focus. For more on grassroots interventions designed to reach the societal sphere, see Sen, R. (2003). *Stir it up: Lessons in community organizing and advocacy*. San Francisco, CA: Jossey-Bass and Finn, J. L. and Jacobson, M. (2008). *Just practice: A social justice approach to social work* (2nd ed.). Peosta, IA: Eddie Bowers Publishing Co., Inc.

relationships, programs focused on individual change will never have an impact on IPV.

IPV agencies are, on the whole, individually-oriented and the shift to community-level interventions is significant for both the approaches agencies take to the work and their organizational structures (Kulkarni et al., 2012). One way agencies might do this is by enhancing their partnerships with other agencies toward preventive impact. Cohen and Swift (1999) contend that effective prevention programs must seek to change organizational practices, not only internally but also among other agencies responding to violence. Because most IPV agencies are the only in their communities that explicitly or singularly address IPV, they often assume that they are the only agencies in their communities providing services for the problem (Kulkarni et al., 2012). However, when one considers the pervasive nature of IPV and its impact on multiple facets of a victim's life, this assumption proves problematic. When a school guidance counselor converses with a student about witnessing IPV in her home, that guidance counselor becomes an IPV service provider. When a nurse in a substance abuse recovery facility treats a patient whose drug problem developed as a result of her partner's control, that nurse is an IPV service provider. When a community homeless shelter provides a bed for a woman who fled abuse in her home and who, whether for lack of knowledge or lack of space, did not seek shelter at an IPV agency, that homeless shelter is an IPV service provider. IPV agencies can engage in community-level interventions by using their expertise to increase the capacity of these various providers to respond

to IPV appropriately and preventatively. Positioning other agencies as IPV service providers holds the benefit of casting IPV as a community problem rather than the problem of one single agency. Increasing capacity can take the form of training other providers in IPV dynamics and interventions, consulting with them on agency policies and procedures, and helping these agencies identify where they might be able to reduce risk and offer more protection to victims.

The Colorado Department of Public Health and Environment developed a promising model for addressing these risk and protective factors through agency partnerships. The Colorado Bold Steps plan for youth violence prevention encourages identifying and addressing shared risk and protective factors (Hindman and Breitzman 2006). For example, there are several risk and protective factors common to both IPV and substance abuse (CDC 2013b; National Institute on Drug Abuse [NIDA], 2003).[11] If IPV agencies work with community substance abuse facilities to identify those factors and address them through their direct service with IPV survivors, they increase their preventive efficacy in the community. Furthermore, by increasing the capacity of other providers, who themselves are generally oriented toward individual-level interventions, IPV agencies can dedicate more resources to community-level interventions where they are likely to have the greatest preventive impact and away from individual interventions where preventive efficacy is low (Powell 2001).

[11] These include low academic achievement, aggressive or delinquent behavior as a youth, antisocial personality traits, having few friends and being isolated from other people at the individual level, unhealthy family relationships and interactions at the relationship level, and poverty at the community level.

Beyond this, IPV agencies can develop and foster coalitions among community agencies which target shared risk and protective factors as epiphenomena of social injustice. While most IPV agencies are involved in community-wide coalitions and task forces, these groups often fail to engage in substantive prevention work (Kulkarni et al., 2012). Instead, as Finn and Jacobson (2008) contend, these coalitions are often either mere check-in meetings for agencies to report on what they are doing or ad hoc groups which address a particular problem then disband. These kinds of coalitions fail to have preventive influence because, while they are community-level interventions, they do not address the underlying community structures which create the problems they seek to ameliorate. Integrating prevention means re-evaluating and transforming the way IPV agencies approach coalitional involvement.

Structuring Interventions through a Health Equity Lens

Health equity literature is helpful in bridging the social justice and public health approaches separately adopted by IPV agencies and in understanding how IPV agencies might engage in coalitions using prevention as a core operating principle. Braveman and Gruskin (2003) define health equity as "the absence of systematic disparities in health between groups with different levels of underlying social advantage/disadvantage" (p. 254). In their report on violence and health equity, UNITY (2012) members contend that violence is a form of health inequity related to the history of oppression against socially marginalized groups. This history is marked by institutional actions which have created risk factors and

impeded protective factors among oppressed populations. Egerter, Barclay, Grossman-Kahn, and Braveman (2011) echo this, contending that violence can be directly linked to social disadvantage. Cohen, Davis, and Graffunder (2006) identify patriarchy, heterosexism, racism, and classism as the most salient forms of oppression underlying this disadvantage and argue for building broad-based, community coalitions which address health inequities by engaging in anti-oppression initiatives. Parks et al. (2007) argue that coalitions move prevention initiatives beyond an explicit emphasis on violence by equally emphasizing the social disadvantages linked to violence like employment, healthcare, and housing inequities.

Under this health equity umbrella, IPV agencies can transform their approach to coalitions by addressing the social and structural conditions which foster violence as well as social issues of concern to their community partners. In this way, Parks et al. (2007) argue IPV agencies can position their work as, "on the way and not in the way of other community priorities" (p. 7). The Colorado Bold Steps model can help these coalitions develop concrete, communal-level interventions which enhance the ability of each partner to address the health inequity of primary concern to them by targeting shared risk and protective factors.

INTEGRATING PREVENTION ACROSS THE SOCIAL ECOLOGY: ORIENTING INDIVIDUAL SERVICE FOR COMMUNITY EFFECT

Shifting from a primary focus on individual-level interventions to one that prioritizes community is certainly not an easy change. For decades, IPV agencies

have built their structures around a core of individual service and most are required by state-wide coalitions and funders to sustain these services. However, Piran's (2010) approach suggests there are ways in which individual-level interventions can be leveraged into community-level impact. By engaging clients in critical dialogue, uncovering and addressing context-specific risk and protective factors in a gendered framework, and positioning clients as agents of social change, IPV agencies might be able to combine individual service provision with community-level interventions.

For example, Parks et al. (2007) suggest that agencies might provide opportunities for the individuals they serve to share their stories at community events. This practice should involve a critical dialogue about participant's experiences in which their victimization and increased risk are positioned as epiphenomena of their gender oppression. Parks et al. (2007) argue that by sharing critical victim narratives in communal spaces, we challenge the norm that IPV is a private, individual matter and encourage communities to support victims. Furthermore, we challenge the othering so characteristic of oppression by positioning victims of IPV as members of one's own community. This does not require violating client confidentiality or creating vulnerability. Clients might, for example, express their experiences through art displayed in a community show.

The Art in the Market project in Cincinnati provides an excellent example of gearing work with individuals toward community-level intervention (Brydon-Miller, 2004). In July 2001, following a series of riots in Cincinatti's Over the Rhine neighborhood, a group of university art students partnered with a social service

agency to recruit adolescents from the neighborhood for a mural project (MacDonald, 2001).[12] Artists engaged these youth in critical dialogue, and then worked with them to design murals communicating their feelings about the violence to which they had been exposed. The students, social workers, and participants then assessed the built environment of the neighborhood, identifying vacant properties and broken windows over which they placed plywood for their murals; Aboelata et al. (2011) have identified supportive built environments as a protective factor for community violence (Brinker and Hutzel, 2002). On a broad, communal scale, students expressed their intolerance for violence; their placement of plywood on vacant properties and over broken windows made structural changes that contributed to a more supportive built environment. In this way, participants were positioned as agents of social change and engaged in dialogue to both address their own experience of trauma and develop a preventive intervention which affected context-specific, communal risk and protective factors for violence.

Agencies might also gear themselves toward community-level solutions through individual service by recognizing that their clients are members of communities. Before clients even seek services at an agency, they find themselves situated in particular communities, some of which are more vulnerable to violence than others. Aboelata et al. (2011) contend that neighborhood-directed interventions are more effective strategies for social change because they build on the power of

[12] Over a six year period from February 1995 to April 2001, fifteen young black males were killed by police or died in their custody in Over the Rhine, a neighborhood rife with risk factors and lacking in protective factors for violence. Beginning April 9, 2001, four days of rioting broke out in Over the Rhine that resulted in intense violence, police brutality, and significant property damage.

individuals who share a built environment to recognize a problem and mobilize around it. Agencies can work to identify those neighborhoods most vulnerable to violence in the areas they serve and prioritize their residents for service provision. This might mean identifying particular neighborhoods with high rates of IPV, low levels of protective factors and high levels of risk factors, and then specifically targeting these communities for outreach efforts and service provision. Perhaps IPV agencies, which on the whole are generally strapped for shelter space, might prioritize beds for individuals coming from high-risk neighborhoods. This can also involve identifying not physical but social communities most vulnerable to violence – women of color, low income women, disabled women, and Trans women – and prioritizing outreach efforts and service provision with these communities.

Working with their own shelter residents, agencies can also bolster the protective factor of social support by helping clients build community with one another. This can be accomplished through regular community-building activities with residents like engaging clients in critical dialogue about individual or residential problems and coming to collective solutions. UNITY (2012) members identified social cohesion and willingness to intervene on a community member's behalf as strong protective factors against violence. Agencies might also gear individual service toward community interventions by constituting IPV survivors as a distinct community to which their clients belong and which can be made more cohesive and organized against injustice. As Piran (2007) contends, effective feminist prevention programs should position participants as agents of social

change. The movement to prevent HIV/AIDS offers several promising examples for how this might be done.[13]

For example, the group *Call Off Your Old Tired Ethics* (COYOTE), a prostitution service agency in San Francisco, provides a promising example for IPV service providers because COYOTE constitutes itself first and foremost as a direct-service organization. Yet, the work of COYOTE demonstrates that social change is central to what it does and organizing its client base toward HIV/AIDS prevention is among its most vital functions. In 1987, COYOTE initiated the California Prostitutes Education Project (CAL-PEP), a service that organizes their individual clients to engage in community outreach and education with other prostitutes around HIV/AIDS prevention measures. A similar project was organized during the same period on the other side of the country in Washington, D.C. to reach intravenous drug users. The Whitman-Walker Clinic, a gay men's health service agency, organized their clients under the AIDS Education Outreach To the Alienated (AORTA) project which involved education, needle distribution, and

[13] From the beginning of the HIV/AIDS prevention movement, those living with AIDS were among the most potent organizers in community education and policy advocacy. Groups like the AIDS Coalition to Unleash Power (ACT-UP) and the Treatment Action Group (TAG) formed in the 1980s as people living with AIDS constituted themselves as a distinct community and leveraged their collective efficacy to fight for research, medical access, and primary prevention of HIV transmission through education and condom distribution. These groups functioned simultaneously as service provision and social change agencies which politically organized and met the basic needs of individuals who made up their distinct community. For more on feminist approaches to HIV/AIDS prevention, see Schneider, B. E. and Stoller, N. E. (1995). *Women resisting AIDS: Feminist strategies of empowerment.* Philadelphia, PA: Temple University Press.

referrals to direct-service for those at-risk for or infected with HIV/AIDS (Schneider and Stoller, 1995).

The work of COYOTE and the Whitman-Walker Clinic challenges the notions that direct-service and social change are distinct agendas and that it is inappropriate to involve clients in advocacy work. There is a tendency among IPV service providers to view clients as vulnerable and to see direct-service provision as the only appropriate intervention with survivors of IPV. Agencies often expect their clients to be in crisis and in need of services like counseling and shelter rather than expecting them to be potentially powerful agents of social change (Burgess-Proctor, 2011; White 2006). However, Piran's (2007) feminist model tells us that approaching our clients in this way holds tremendous potential for prevention. Whalen (1996) further suggests that agencies raze the wall between counseling and social change not only in the interest of preventing IPV but also, and more importantly, in providing a means of treatment and healing for clients. Whalen contends that engaging clients in social change work is an important component of helping them "practice power and seize power" of which they have been robbed in abusive relationships (p. 108). In this way, agencies can help clients heal from the violence they have experienced and potentially address individual-level risk factors like low self-esteem and emotional insecurity while also organizing the social justice work necessary for IPV prevention.

INTEGRATING PREVENTION ACROSS THE SOCIAL ECOLOGY: SECONDARY AND TERTIARY PREVENTION IN THE RELATIONAL AND INDIVIDUAL SPHERES

Engaging clients in advocacy helps agencies bridge the tripartite prevention model and target interventions toward the social environment as Piran (2010) encourages. Yet, the claim by many IPV agencies that their clients are in crisis and in need of direct service certainly is not a baseless one. While engaging clients in advocacy can be an important part of healing and helps agencies orient interventions toward the communal sphere, service is still needed in the individual and relational spheres (Lyon, Lane, and Menard, 2008). Using prevention as a core operating principle and integrating it into agency direct service means positioning these other kinds of services to victims as secondary and tertiary prevention. This requires structuring such interventions to reduce or eliminate risk factors and create or bolster protective factors in the individual and relational spheres. As Piran (2010) contends, our service to clients should link these factors in a gendered framework and address them in context specific ways.

Agencies might do this by rethinking approaches to casework. While an abundance of literature offers diverse, promising approaches to feminist case work, none of these approaches are structured to address risk and protective factors for IPV (Fawcett, Featherstone, Fook, and Rossiter, 2000). It seems that for IPV service agencies, all case work should be designed around risk and protective factors for clients and their families. Case workers can engage their clients in a critical

dialogue about risk and protective factors in their lives and help their clients understand their victimization by linking these factors in a gendered framework. Advocates might assess for risk and protective factors using client self-reports as well as evidence-based tools which gauge indicators of particular factors, like the NIDA (2012) motivational substance abuse assessment or the Arizona self-sufficiency matrix (Arizona Department of Economic Security, 2006).[14] Even this individual work holds potential for positioning clients as agents of social change because these kinds of dialogues help clients build a feminist consciousness wherein they can understand their risk for harm as a result of oppression. Beyond casework, the same kinds of critical dialogues might also be employed in support groups and family counseling sessions.

Critical dialogues of this kind help agencies improve the context specificity of their prevention work. Piran (2007), in developing her feminist model for prevention, was seeking to develop programs for the primary prevention of eating disorders among girls. When she engaged girls in a particular school in a critical dialogue about negative body image (a risk factor for adolescent eating disorders), she found that this risk factor was most saliently linked with gang involvement among the students. Thus in that context, gang involvement was identified as a risk factor for eating disorders and Piran structured the program to effectively address it. The same approach can be applied to the direct service work of IPV agencies. In

[14] While client self-report can be a useful means of identifying risk and protective factors for IPV Murray and Graybeal (2007) find that IPV agencies tend to over rely on these kinds of reports and often fail to adequately identify the extent and nature of potential risk and protective factors in the lives and social environments of their clients.

addition to addressing risk and protective factors found in the literature, IPV agencies should study their client's narratives for commonalities which can be positioned as context-specific risk and protective factors. Evans (2005) contends that a vital component of feminist advocacy involves questioning women about their lives in the particular contexts in which they find themselves and analyzing client responses to identify connections between their lived experiences and unjust axes of power fostered by policies, practices, and communal belief systems. By identifying gendered risk and protective factors and linking these with systemic and communal manifestations of oppression, advocates can not only improve secondary and tertiary prevention with victims but also make primary prevention initiatives more effective in their context specificity.[15] Furthermore, when mining client narratives in this way, agencies can identify where help for victims is lacking and advocate for change at the communal level. Cohen, Davis, and Graffunder (2006) contend, "powerful advocacy movements tend to arise from victims, survivors, and their families who have suffered and/or have been in need of services that were not available" (p. 91).[16]

Using these kinds of critical dialogues to truly improve direct service involves humility and a genuine commitment to change on the part of IPV agencies.

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[15] Over the course of completing this project, I have had the opportunity on several occasions to discuss my research with clients of the agency where I work. On every occasion, clients' responses have included a desire that someone ask them about their experiences getting into abusive relationships so that we as professionals might learn how to address these risks among young people and better prevent future IPV. This reflects some insight into the context-specificity of risk factors and desire of clients to be a part of shaping prevention initiatives.

[16] For more on how agencies can use client narratives to identify context-specific risk and protective factors and structure interventions, see Stephens, A. (2011). Feminist systems theory: Learning by praxis. *Systemic practice and action research, 25,* 1-14.

Attending to risk and protective factors and listening to client narratives, agencies might discover that services they have worked long and hard to develop, services they see as vital to their missions, services for which they receive a great deal of funding, may in fact need to be significantly transformed or eliminated. However, if agencies are committed to prevention as a core guiding principle, this is critical. Bill Shore and Darell Hammond (2013), Presidents of Share Our Strength and KaBoom respectively, argued in the *Stanford Review of Social Innovation* that when they shifted to setting bold, preventive goals for their organizations, they had to be willing to let go of important programs and funders and both experienced significant resistance from their boards as a result. Yet, it was only by doing this that they were able to go from individual-level interventions for which they saw few social results to significant, measurable social change. Ultimately, both organizations saw an increase in funding and support by committing to bold goals and waiting for long-term results.

To make the potential impact of this kind of commitment palpable for IPV service agencies, let us consider perhaps the most venerated of direct services, emergency shelter. IPV agencies in fact began as a battered women's shelter movement and even into the twenty first century, shelter generally remains core to IPV service provision; Lyon et al. (2008) found that approximately ninety five percent of IPV agencies in the U.S. offer emergency shelter. Now, among the factors identified by the CDC, shelter is not a protective factor in any sphere of the social ecology. Wathen and MacMillan (2003), in their comprehensive review of program-

specific risk and protective factors for IPV, found no difference in reported rates of violence between women who had stayed in an IPV shelter and women who had not. Furthermore, they found that for some women, the risk for IPV actually increased following shelter stay. IPV agencies might counter that shelters nonetheless serve as a protection from lethality for their clients, who otherwise might be killed by a partner. Yet, Browne, Williams, and Dutton (1999) found that, at the state-level, access to emergency shelter was negatively correlated with female homicide of male partners but not significantly correlated with male homicide of female partners. This finding implies IPV shelters have been effective in protecting abusers, rather than victims, from lethality (Stelloh 2012). While this might ultimately protect victims from incarceration or even capital punishment, IPV agencies are in the business of addressing violence, not imprisonment.

This is not to suggest that all IPV agencies should immediately shut down shelter operations. Indeed, Lyon et al. (2008) found that residents of IPV shelters generally saw their prospects as dire if they were not able to secure a bed in a shelter. IPV agencies should certainly not be in the business of discounting women's identified needs in the interest of responding to literature regarding shelter as a risk or protective factor for violence. However, these findings are a call to challenge our assumptions about the preventive efficacy of basic IPV services with a willingness to change. In fact, IPV agencies might find that by integrating prevention as a core operating principle to transform service provision, they will discover better ways of providing these basic services, including shelter, so that they

have a genuine impact on reducing rates of IPV victimization and lethality in the U.S.

LAYING THE GROUNDWORK TO INTEGRATE PREVENTION

A sincere commitment to transform service provision by integrating prevention as a core operating principle requires that IPV agencies foster buy-in and competence among their leadership and staff. Literature on integrating prevention in the field of sexual violence service provision strongly emphasizes this necessity. Lyles and Tsao (2012) contend that among sexual violence service agencies, changes designed to integrate prevention were not possible unless there was strong support among an agency's administration. Parks et al. (2007) echo this sentiment, contending that, "leadership development is needed for new and existing leaders to foster new ways to push the envelope of prevention" (p. 14). Similarly, Townsend (2012) found among sexual violence service agencies that prevention was more successfully integrated when leadership committed to prevention as core to the work and institutionalized this commitment by cultivating staff and leadership investment. Townsend's report offers several examples for how this might be done. She found that where prevention was successfully integrated: all programmatic decisions were made according to their preventive impact, staff were given genuine opportunities to determine prevention strategy, agency departments were required to define their preventive impact, all staff and board members were trained on prevention frameworks, prevention was explicitly stated in agency missions, all staff were given opportunities to conduct primary prevention programs like

community mobilization and education, and where there might be a standing prevention department, it was staffed cross-departmentally.

Large scale transformation is important if prevention is to become a core operating principle. However, not every IPV agency is well positioned or even interested in making prevention the core of its work. In these cases, the literature on violence prevention and IPV service provision suggests several ways to begin forging a path for integrating prevention by making minor shifts in direct service to victims. Thinking metaphorically, the most expeditious way to reach the core of an apple is to cut right through, but you can also get there by taking small bites; the same can hold true for IPV service. Agencies and even individual staff members can take these small bites by beginning where they are with direct service, and gradually initiating processes which shift operations toward greater preventive efficacy over time – processes that might ultimately open the path for more large scale changes with the promise of significantly reducing rates of IPV. To provide one illustration for how these shifts might be made, we will consider one IPV service agency as a case study on integrating prevention.

THE CENTER FOR WOMEN AND FAMILIES: A CASE STUDY

CWF is a not-for-profit organization based in Louisville, Kentucky and serving a total of nine rural and urban counties in Kentucky and Indiana. The mission of CWF (2013b) is to "help victims of intimate partner abuse or sexual violence to become survivors through supportive services, community education, and cooperative partnerships that foster hope, promote self-sufficiency, and rebuild

lives" (p. 1). The agency's services are broken into six major programs: outreach, economic success, clinical services, children's program, residential operations, and prevention (CWF, 2013a). Table 1 details services provided under each of these major programs.

Table 1

CWF Programs and Services

Outreach	Economic Success	Clinical Services	Residential Operations	Children's Program	Prevention
· Non-residential counseling/ case work · Support groups · Legal advocacy · Community coalitions/ advisory boards	· Financial planning/ case work · Economic literacy education · Housing · Asset building/ individual development accounts · Community coalitions	· Counseling/ case work · Therapy · Art therapy · Support groups	· Emergency shelter · Walk-in and telephone crisis counseling · Residential counseling/case work · Food services · Support groups · Medical advocacy · Transportation assistance	· Counseling/ case work · Therapy · Support groups · Academic support · Parenting support · Community coalitions	· Neighborhood-based dating violence prevention · Green Dot program · Awareness education · Professional training · Community coalitions

Like most IPV agencies, the prevention initiatives of CWF generally function in a silo. A team of six full- and one part-time staff members carry out the agency's prevention initiatives under the direction of the Vice President of Programs.[17] The Prevention Education team has made some steps toward integrating prevention; however, the bulk of agency work and the direction of the agency's focus remain with direct service to victims. Attempts at integrating prevention include allowing all staff the opportunity to facilitate awareness education programs in the community, facilitating an agency-wide awareness and prevention committee,

[17] I, the author, have been a member of this team since March 2007.

conducting trainings for staff on prevention and the Green Dot program, and cross-departmental staffing whereby one member of this team is also a member of the children's program team.[18] This cross-departmental staffing in particular has had a promising impact on further integrating prevention: the children's program has begun to structure itself around addressing risk and protective factors for IPV and one client of the children's program has been recruited as a member of a prevention-focused coalition to addresses children's exposure to violence

These incremental changes suggest limited progress toward integrating prevention at CWF. Let us consider what it might mean for the agency to operate with prevention as its core principle by considering a few, key suggestions uncovered in the review of the literature above. These include constituting the agency as feminist, re-orienting the agency's focus from the individual to the relational and communal, positioning clients as agents of social change, and increasing leadership and staff competence.

To begin, an important first step for CWF to integrate prevention as a core operating principle would be constituting itself as a feminist organization. Nowhere in the agency's mission, vision, publications, or trainings is a feminist orientation mentioned. While the organization certainly grew out of the feminist movement of the 1970s, like many IPV service agencies CWF has de-radicalized over time to become a social service rather than activist organization. Because sexist oppression

[18] Green Dot is a violence prevention program which seeks to engage bystanders in proactive and reactive interventions to stop intimate partner violence, sexual assault, stalking, and bullying. CWF is currently part of a CDC-funded research pilot of the Green Dot program in the Commonwealth of Kentucky, conducted by the University of Kentucky, led by Ann L. Coker, Ph.D. For more information on the Green Dot program, see http://www.livethegreendot.com/gd_strategy.html

is at the root of IPV, to achieve preventive efficacy CWF must place challenging this oppression at the heart of its identity. Lyles and Tsao (2012) as well as Townsend (2012) all found that institutionalizing feminism was an important first step for sexual violence service agencies in integrating prevention; IPV, like sexual violence, has its roots in sexist oppression. It is important that the agency adopt a feminist approach not based singularly on gender, but rather one which recognizes the intrinsic link between sexism and other axes of oppression that put racial/ethnic, lower-income, and bodily marginalized women at heightened risk for IPV. Adopting a feminist identity would have implications for how all advocates carry out their work because this identification encourages staff to approach with a social justice orientation. It provides a lens for the agency to assess its work and develop programs with the root cause of IPV in mind. Furthermore, positioning itself as a feminist organization would benefit CWF in recruitment and hiring processes by attracting qualified individuals interested not just in service provision but also social change, helping to shift the agency over time to a preventive focus.

Reorienting from direct service to feminist social justice is an important first step in shifting focus from individual service provision to intervention at the community level where CWF is likely to have the greatest preventive impact. CWF, like many IPV agencies, dedicates the bulk of its resources to individual-level service. With prevention as a core operating principle, CWF would benefit by implementing recommendations for enhanced community-orientation found in the literature. For example, CWF currently employs only one staff person focused on

training other agencies in the community to increase their capacity for IPV identification and response. However, training alone is insufficient to actually change organizational practices. Furthermore, these trainings teach other providers how to recognize IPV among the clients they serve but does not train them in prevention skills; rather, other agencies are taught that appropriate response involves referring to CWF rather than providing any IPV-informed services themselves. Training instead should focus on casting IPV as a community problem to which all agencies must respond and it should be accompanied by consultation and skill development which recognizes community partners as fellow IPV service providers with preventive potential. CWF could determine how many of its resources should be shifted toward increasing this capacity among other providers by assessing its current efforts in this regard, determining how many agencies its one staff person has been able to reach through training and what impact this has had on these agency's operations. From here, CWF can use its community directory of social service agencies in its region to identify those providers likely to serve survivors of IPV and/or likely to have an impact on IPV risk and protective factors. CWF should prioritize those providers who serve vulnerable populations and who are able to have an impact on multiple risk and protective factors for IPV. Determining how many agencies it would like to reach and what kind of capacity it would like to develop in these agencies, CWF can determine how many resources in terms of staff time and overhead it would take to make this kind of impact and begin reallocating those resources.

CWF could also re-orient itself toward communal level interventions by building important community relationships focused on addressing health inequities and risk and protective factors for IPV. The agency should determine those communities in its service area most vulnerable to IPV by looking at data from police departments, school systems, and other social service providers. Vulnerable communities are those with high rates of violence, few protective and high risk factors, and limited access to resources (Cohen, Davis, and Graffunder, 2006). CWF should identify leaders in these communities and engage them in critical dialogue about reducing rates of IPV by taking preventive action.

CWF might begin this work with the neighborhood immediately surrounding its main campus, Old Louisville. In 2012, this neighborhood had more police reports for IPV than any other in Louisville (Louisville Metro Police Department, 2012). The Center for Neighborhoods (2010) found that Old Louisville has high rates of risk factors for IPV including poverty and overcrowding. This is an ideal neighborhood in which to begin communal-level prevention work because it is both a neighborhood with high vulnerability for IPV and the neighborhood in which the agency's main campus is located. Yet, CWF does not maintain strong connections with its neighbors or community groups. CWF is not involved in Old Louisville's neighborhood association and the agency demonstrates some hostility to the neighborhood itself. In the spring of 2013, the agency launched a committee on staff safety because of fears that the surrounding neighborhood is dangerous. This committee has focused on individual-level interventions to protect staff—and these

interventions, including identification badges to demarcate staff from community members and increased signage and security around the building, further alienate CWF from its surrounding neighborhood. It seems CWF might better integrate prevention by taking efforts to make Old Louisville safer rather than cordon itself off from the neighborhood. CWF should advocate for structural changes in the neighborhood which would help it build social capital and thus be at decreased risk for violence.

Structural changes often require policy advocacy, another area where CWF might improve its integration of prevention. CWF generally defers policy advocacy to its state-wide coalition, the Kentucky Domestic Violence Association (KDVA). KDVA, however, is not involved in policy advocacy at the local level and CWF itself has very little involvement in this regard. CWF fails to engage with the Louisville Metro Council except for requesting funds or when the council's work is directly related to IPV.[19] Yet, this council regularly discusses and legislates on risk and protective factors for IPV. For example, as of the fall 2013 the council has been debating an ordinance to ban liquor store sales after 2 a.m. (Shafer, 2013). Gruenwald (2013) found that alcohol availability is directly linked with heavy alcohol use, a CDC-identified risk factor for IPV. Yet, CWF has in no way been involved in discussions or advocacy around this ordinance. CWF should be involved in policy work addressing risk and protective factors for violence, particularly at the community level where it is likely to have the greatest preventive impact. CWF can

[19] For example, CWF attended a Metro Council hearing in February 2012 to accept an official recognition declaring February teen dating violence awareness month in Louisville.

further its preventive efficacy by involving clients in this advocacy work. For example, during the Kentucky legislative session, KDVA sends advocacy alerts to its member programs encouraging them to contact legislators about bills related to IPV. While CWF shares these alerts with their staff, there are no regular mechanisms for sharing this information with clients. As Cohen, Davis, and Graffunder (2006) contend, survivors are some of the most powerful advocates for social change. By developing practices to share advocacy alerts with clients, CWF can have a greater impact on influencing policy and can better integrate prevention by positioning clients as agents of social change.

CWF can also better orient itself toward community through its direct client service. CWF could facilitate opportunities for clients to share their stories at the community level and in fact is well positioned to adopt recommendations around using art to do this. CWF employs a full-time art therapist who regularly works with clients to use art as a mechanism of healing from trauma. Many of these pieces are displayed around CWF's Louisville shelter, including a series of mosaics completed by clients as part of the Kentucky Foundation for Women's *Healing Mosaics* project, and a narrative mural completed by four clients with the Louisville Visual Art Association. In CWF's building though, these pieces of art have little community-level impact. CWF should share this work at the community level in order to affect norms which support violence.

Besides having limited influence on the communal level of the social ecology, CWF could also improve its interventions at the relational level. CWF can better

integrate prevention by developing and supporting interventions to prevent violence which address relational-level risk and protective factors. Currently, the children's program is the only arm of CWF that engages in family interventions through its parenting support work. CWF employs three full-time therapists, two of whom are marriage and family therapists, but these therapists conduct only individual sessions with survivors. CWF might influence the relational level by offering therapy to whole families affected by IPV. Furthermore, CWF can help clients build strong supportive connections with one another which focus on addressing relational level risk factors for IPV. House meetings and support groups with shelter residents provide an excellent opportunity to do this. Currently, house meetings are structured so staff can update residents on organizational policy issues and allow residents to request staff intervention on shelter issues. Support groups are structured to teach clients relationship skills. These meetings might be restructured to provide opportunities for clients to engage in collective problem solving and build connections with one another. Advocates can guide the conversation by asking specific questions about risk and protective factors in clients' lives and have the group offer support and ideas for intervention. There is some concern at the agency about clients sharing personal information in the group setting for fear other residents will not keep this information confidential or will create more vulnerability for the client. It is important to recognize however that shelter living is community living. Clients share rooms, spend social time together, share one computer in an open space, and care for one another's children. Personal

disclosures in this context are unavoidable and fostering an environment of secrecy around personal issues only supports a sense of shame and embarrassment. By structuring and supporting opportunities for clients to build strong interpersonal connections which help ameliorate risk factors and bolster protective factors, CWF might not only better integrate prevention but also foster an environment where communal connection rather than privacy and secrecy are the norm. The Prevention Institute (2007) identifies privacy as one of the norms which supports IPV.

At the individual level, CWF can better integrate prevention by focusing work on risk and protective factors for IPV. Currently, there are no agency-wide standards for individual case work and advocacy. Advocates must work with clients to develop goals and all clients complete a strengths and needs assessment, but these practices rely on clients' self-report and personal identification of goals and fail to be consistent from advocate to advocate. CWF could benefit from a more comprehensive assessment process that uses proven tools to identify risk and protective factors for violence in a gendered framework by identifying personal indicators of these factors. In adopting this kind of process, advocates would educate clients on the risk and protective factors for IPV and position them as agents of social change by helping them see the ways in which they are socially located in matrices of oppression at the root of their vulnerability. This would help improve the preventive efficacy of clients who would better understand their increased risk for IPV and develop mechanisms for addressing risk and protective factors in their lives. Furthermore, it would raise the critical feminist consciousness of clients,

further supporting their roles as powerful agents for social justice. Advocates should ask critical questions not only about individual experiences but also about the client's community of origin and experiences of family in order to help clients understand the influence of the social ecology and aid the agency in identifying those elements of the social environment and relationships that contribute to their clients' increased vulnerability for IPV. If CWF engages clients in these kinds of critical dialogues about risk and protective factors as epiphenomena of sexist oppression, they also create opportunities to identify further, context-specific risk and protective factors for violence in the communities they serve which could inform on-going prevention efforts.

Though these programmatic considerations suggest ways CWF can further integrate prevention into its work, ultimately the agency must make a strong commitment to prevention demonstrated by a willingness to transform its approach to service provision. CWF is so strongly focused on individual service provision that integrating prevention would mean significant restructuring of programs and resources. In order to have the most preventive efficacy, CWF should focus the bulk of its work on primary prevention at the community level. Of the agency's nearly ninety staff members, only seven currently focus on primary prevention and of those, only three conduct the majority of their work at the community level. If CWF is going to integrate prevention, it must be willing to let go of programs and redirect its resources to the primary prevention of IPV. This could have stark implications for the agency. For example, the bulk of CWF's resources are dedicated to

maintaining its emergency shelter which, at just over one hundred beds, is more than three times the national average in terms of shelter size (Lyon et al. 2008). Reallocating resources to primary prevention should be expected to have a significant impact on emergency shelter services in the long term. However, by adopting practices which re-orient individual interventions, like shelter, toward community impact, CWF can leverage the support it receives for direct service toward primary preventive efficacy. In fact, integrating prevention into its direct service work should begin precisely where the agency's strongest and most stable forms of support are allocated.

CONCLUSION

At the precipice of this new stage in IPV prevention identified by Parks et al. (2007), integrating prevention into direct service operations holds promise for stemming the tide of IPV perpetration in the U.S. IPV agencies are ideal sites for grassroots social change work to prevent IPV because they span the entire nation and have such a strong stake in ending violence. Positioning these agencies for greatest preventive efficacy means beginning where they are with direct service to victims and considering how prevention can be integrated into their operations. While the greatest efficacy is achieved by making prevention a core operating principle, this kind of commitment may not be easily adopted at many IPV agencies. The prevention literature tells us that shifts in service provision over time can move agencies to a place where prevention is treated as constitutive rather than

ancillary. Only by getting to this place can we in the IPV service community rightly claim that we are indeed putting ourselves out of business.

In the interest of facilitating this kind of shift, further research is needed on IPV prevention and service provision. While researchers have identified an abundance of risk factors for IPV, very few protective factors can be found in the literature. It is insufficient to assume that protective factors are the inverse of risk factors. The CDC can tell us that conflict in the family is a risk factor for IPV, but cannot tell us what kinds of family dynamics might function as a protective factor against it. Fostering healthy families requires that we do more than avoid conflict; we must be able to identify and facilitate the kinds of families which function as protection against IPV. Context-specific participatory action research with IPV victims might be one way to do this. This kind of research would help agencies identify risk and protective factors specific to the regions they serve and would help position their clients as agents of social change. More researchers should take an interest in conducting this kind of research with IPV agencies and should also train agency staff on PAR methods in order to make projects like this sustainable. As agencies transition over time to further integrating prevention into their operations, more research will be required on how well these transitions are facilitated and what preventive impact they have. This kind of research exists with sexual violence and HIV/AIDS service agencies and will be required of efforts to integrate prevention in IPV agencies going forward.

Analyzing the ways in which prevention might be integrated into service provision also calls for more general, structural analyses of IPV service agencies' preventive potential. Structural analyses should investigate agency leadership, uncovering ways in which boards of directors and staff leaders might better facilitate IPV prevention. Researchers should ask which kinds of board members and management styles are likely to have the greatest impact on IPV prevention. Structural analysis is also needed on agency processes, particularly as they relate to transforming IPV agencies from crisis-response organizations to agencies with the long-term focus required of IPV prevention. In this regard, researchers and service practitioners should work to determine appropriate timelines for integrating prevention with attention to the size, scope, needs, and capacities of individual agencies. Where capacity is low, funders, community groups, state-wide coalitions, and policy makers should respond with the necessary resources to increase the preventive efficacy of IPV service agencies.

IPV agencies have come a long way in their preventive efforts, from early awareness campaigns to developing programs around comprehensive public health models that span the social ecology. However, agencies have generally not used new models to re-evaluate the very ways they approach their work with a willingness to engage in the kind of large-scale transformation that would shift the field from IPV response to prevention. Sexual violence and HIV/AIDS service providers have led the way by developing methods to integrate prevention and positioning prevention as core rather than ancillary to direct service. The time is ripe for IPV agencies to

apply valuable lessons from these providers and employ public health and social justice frameworks toward organizationally transformative work with the promising of ending the epidemic of IPV.

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Appendix

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