



**ISSUE BRIEF SERIES: EXPLORING THE SOCIAL DETERMINANTS OF HEALTH
VIOLENCE, SOCIAL DISADVANTAGE AND HEALTH – MAY 2011**

This is one in a series of 10 issue briefs on the social determinants of health. The series began as a product of the Robert Wood Johnson Foundation Commission to Build a Healthier America and continues as a part of the Foundation's Vulnerable Populations portfolio.



How Social Factors Shape Health: Violence, Social Disadvantage and Health

1. Introduction

Few would deny that violence is a major problem in the United States today. Violence is a mainstay of news coverage, and the statistics are staggering. Each year, for example, more than 18,000 Americans are victims of homicide. Many more suffer the physical and emotional effects of violent injuries, losing loved ones to violence, or witnessing violence in their homes, schools, workplaces and neighborhoods.¹ The economic toll on society is enormous as well—in 2007, for example, the total lifetime cost in medical care and lost productivity from violence-related deaths and nonfatal injuries nationally was estimated at more than \$37 billion.²

At the same time, most of us are fortunate enough not to personally encounter violence in our everyday lives. Violence is not randomly distributed. The same social factors that shape health—including education, income and wealth, and related conditions where we live, learn, work and play—also are strongly linked to violence, and considering those links can contribute to understanding why some groups of Americans are more affected by violence than others.

Other issue briefs in this series have explored the ways in which social factors influence health and health-related behaviors and contribute to health disparities in this country. Here we focus on the links between violence, health and social disadvantage, examining the health effects of violence on individuals and communities and exploring strategies to prevent violence by addressing the social determinants of health.

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Despite the wide recognition of violence as a major public health problem, the data available for understanding the links between violence and health are remarkably limited. Crime statistics, which are the primary source of routinely-collected information on violence at the population level, rarely include relevant information on health and social factors. Much of the evidence about health and violence described in this brief is based on research findings from special surveys or studies that have focused on predominantly urban, low-income communities. The lack of relevant population-wide data makes it difficult to examine and understand differences in violence across social and economic groups, to track changes in exposure to violence over time, and to measure the impacts of violence prevention strategies.^{3, 4}

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2. The health impacts of violence where we live, learn, work and play

Research on violence typically distinguishes between *direct exposure*, which refers to the experiences of someone who is the actual victim of violence, and *indirect exposure*, which most commonly refers to the experiences of personally witnessing violence but may also include hearing about an act of violence or knowing someone who has been victimized. The available evidence shows that both direct and indirect exposures to violence have serious health consequences for our nation.

VIOLENCE WITHIN FAMILIES

Many Americans experience violence within their own families. Here we focus on two major forms of family violence—*child maltreatment* and *intimate partner violence*. Violence against children and against intimate partners frequently occur together,⁵ each has been linked with adverse health effects.

Although all forms of *child maltreatment* (defined as any act resulting in harm, potential for harm or threat of harm to a child) are likely to be under-reported,⁶ national statistics for 2006 recorded 142,041 children as victims of physical abuse and another 78,120 as victims of sexual abuse. An estimated 82 percent of substantiated cases of child maltreatment were perpetrated by parents or other caregivers.⁷ Available evidence indicates that many victims experience child maltreatment as chronic occurrences, rather than as a single event.⁶ The estimated annual medical cost of child abuse and neglect is more than \$7.7 billion.⁸

In addition to its immediate health impacts, childhood maltreatment has been linked with longer-term adverse effects on cognitive development and on physical and mental health—effects that often persist beyond childhood^{6, 9-12} and result in increased medical care use and costs throughout life.^{8, 13, 14} Child maltreatment is also a major contributor to the caseloads of social service agencies. In 2008, for example, an estimated 3.3 million at-risk children received voluntary or court-ordered preventive services, including children who were removed from their homes and placed in foster care¹⁵—which in turn is linked with poorer health.^{16, 17}

Women are the most frequent victims of *intimate partner violence*, or *IPV* (defined as any threatened, attempted, or completed physical, sexual or psychological violence between adults who are, or have been, intimate partners).^{6, 18} More than 4 million women are assaulted by intimate partners each year,¹⁹ and one in four women reports some form of IPV victimization during her lifetime.²⁰ Other evidence suggests that nearly one-third of homicides among U.S. women between 1993-2004 occurred at the





hands of intimate partners.²¹ Most victims experience multiple forms of abuse (physical, sexual, psychological) and repeated acts of IPV over time.²² Like child maltreatment, intimate partner abuse has adverse effects on both mental and physical health—including increased risk of depression, anxiety, post-traumatic stress disorder, substance abuse and chronic pain—that persist over time, but victims of IPV often do not receive medical attention for their sustained injuries and illnesses.²³ National data indicate that 28.1 percent of women assaulted by their partners receive medical treatment.¹⁹

IPV can have adverse effects on the children of victims as well. Some sources estimate that between 157,000 and 335,000 pregnant U.S. women are abused by their partners each year.²⁴ Research indicates that in addition to the health consequences for the pregnant women as victims themselves, their babies are at increased risk of low birth weight, preterm birth and death during the first month of life, even after considering other social factors such as the mother’s educational attainment and marital status, whether she received prenatal care and how it was paid for, and whether she drank alcohol or smoked during pregnancy.²⁴⁻²⁶ Children exposed to violence between parents or intimate partners appear to be at increased risk of many of the same adverse mental health outcomes associated with childhood victimization itself.²⁷

VIOLENCE IN SCHOOLS AND WORKPLACES

Many Americans spend much of their time in schools and at work, making violence in those settings of great importance.

While most U.S. schools remain relatively safe, *school violence* has been recognized as a significant public health problem. During 2005-2006, for example, approximately 38 percent of public schools reported at least one violent incident of rape, sexual and physical assault, or robbery to police.²⁸ During 2005, more than 600,000 violent incidents were reported among students ages 12-18;²⁹ 7.9 percent of high-school students reported being threatened or injured with a weapon on school property and 13.6 percent were involved in a physical fight at school during the prior year.³⁰ In addition, estimates indicate that nearly one in five high-school students experiences bullying at school,³⁰ and 43.5 percent of middle schools report that student bullying happens at least weekly.³¹ Even more students are indirectly exposed to violence at school as witnesses. One study found that nearly 80 percent of elementary-, middle- and high-school students reported having witnessed a threat of violence at school, and 70 percent had witnessed another student being beaten up at school.³²

Violence in schools takes a serious toll on both victims and witnesses. In 2009, five percent of high-school students reported missing at least one school day during the previous month because they feared for their safety.³³ Research has shown that on any given day as many as 160,000 students leave school early to avoid bullying.²⁸ The fear, anxiety and elevated stress that students experience as a result of a violent school atmosphere have serious psychological health consequences, including depression, anxiety, insomnia and anger.³² Victims of bullying are at higher risk for depression and suicide,^{34, 35} and youth who witness school violence are less likely to practice health-promoting behaviors like walking to school and participating in school athletics and more likely to engage in risky behaviors such as carrying a lethal weapon³⁶ and engaging in aggressive and violent behavior themselves.^{32, 37} In addition, the adverse

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health effects of violence, including violence at school, appear to increase with additional exposures (Figure 1). For example, compared with youths who reported no exposure, those with five or more direct or indirect exposures to violence were six times as likely to describe their health as “fair” or “poor.”³⁸

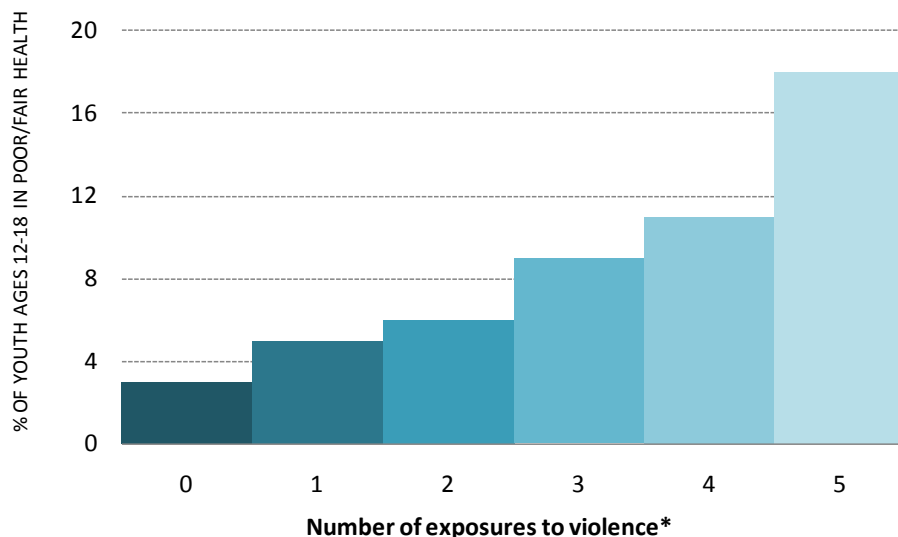


Figure 1. Exposure to violence increases risks for poor health among youths.

*Witnessed gun violence, threat of violence, repeated bullying, felt unsafe at school, or criminal victimization. Source: Boynton-Jarrett, 2006. Data from National Longitudinal Survey of Youth 1997-2004.

Although relevant data are limited, many Americans are exposed to *violence in the workplace*. Crime statistics indicate that serious violent crimes (including rape or sexual assault, robbery, and aggravated assault) occur at an annual rate of 5 per 1,000 employed individuals ages 16 and older, resulting in more than 570,000 violent crimes yearly.³⁹ Of the more than 4,000 *fatal* occupational injuries reported in 2009, 18 percent were attributed to “violent incidents including assaults” and 12 percent were attributed to homicides.⁴⁰

The health impacts of workplace violence extend beyond physical injury and deaths, however. Exposure to work-related violence, whether direct or indirect, is linked with mental and physical health effects similar to those associated with school violence. Evidence indicates that psychological abuse or harassment, bullying and discrimination in the workplace can impair self-esteem, emotional health and cognitive functioning,⁴¹ activating the body’s physiologic stress mechanisms and increasing risks of serious chronic health conditions including heart disease, depression and post-traumatic stress disorder (see the “Stress and Health” issue brief in this series).^{42, 43}

VIOLENCE IN NEIGHBORHOODS AND COMMUNITIES

Direct exposure to violence within communities may take the form of youth or gang violence, random acts of violence, or rape or sexual assault by strangers. In 2009, an estimated 4.3 million violent crimes were committed against U.S. individuals ages 12 and older, including nearly 1.5 million cases of rape, robbery and assault.⁴⁴ Most violent crimes among youth ages 10-24 years take place in the community outside of school.⁴⁵ In this age group, violence contributes to both injury and death: more than 650,000 youths received emergency-department treatment for nonfatal violent injuries in 2008, for example, and homicide is the second leading cause of death.⁴⁶





A growing body of evidence indicates that indirect exposures to community violence have health consequences as well. Perceiving one's neighborhood as dangerous and hearing about violence in the community have been linked with worse psychological health.⁴⁷ Among women in urban low-income neighborhoods, those who witness violent acts are more likely to report symptoms of anxiety and depression than those who have not witnessed violence.⁴⁸ Stress related to feeling unsafe in one's neighborhood can have adverse health effects throughout life, and may even influence subsequent generations. Some studies indicate that neighborhood violent crime rates are strongly linked with adverse birth outcomes such as preterm birth and low birth weight, even when individual-level risk characteristics are taken into account.⁴⁹⁻⁵¹ Adverse health effects among children and young adults include post-traumatic stress disorder symptoms, aggressive behavior, sexual risk-taking, problems with eating and sleeping, and increased likelihood of alcohol, tobacco and marijuana use.^{47, 52-54} The effects can be particularly damaging for children who are exposed to violence on a chronic basis, especially when the violence involves people they know.⁵⁴

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Additionally, the economic costs of violence are staggering—encompassing costs associated with premature death, disability, medical treatment, lost productivity, psychological trauma and the criminal justice system.^{2, 22} For example, the total lifetime costs of deaths and nonfatal injuries due to interpersonal violence occurring during one year in the United States were estimated at approximately \$4 billion in medical costs and \$33 billion in lost productivity; each case of nonfatal assault requiring hospitalization resulted in medical treatment costs of more than \$24,000.²

3. Explaining the links between violence and health

When violence results in injury or death, the links with health are obvious. But how can we explain the evidence linking exposure to violence with other health consequences, including increased risk of chronic disease—especially among those who are not the actual victims of violent acts but experience violence less directly in their homes and communities? Current scientific knowledge tells us that violence can increase people's risks of poor health through several pathways:

- **Violence can affect health-related behaviors.** Witnessing or directly experiencing violence, along with the fear that violence may occur in everyday life, can affect a person's motivation and capability to adopt and adhere to health-promoting behaviors. Concerns about neighborhood violence may limit people's physical activity and eating habits—for example, parents may not let their children play outside or walk to school and may rely on nearby convenience stores or fast-food restaurants rather than traveling to stores with healthier food options. Some people may react to the stress associated with experiencing or witnessing violence—especially on an ongoing, chronic basis—by practicing health-harming behaviors, such as smoking or alcohol and drug misuse, that serve as coping mechanisms (see the “What Shapes Health-Related Behaviors?” issue brief in this series).^{53, 55-57}
- **Violence-related stress—particularly if chronic—may lead to poorer health.** Evidence also suggests that stress related to the occurrence or threat of violence can have direct physiologic effects that make a person more susceptible to poor health (see the “Stress and Health” issue brief in this series). Chronic stress—due to, for example, threats of violence that a person perceives to be completely beyond his or her control—has been linked with more rapid onset and progression of chronic illnesses⁵⁸ and with bodily wear and tear that may accelerate aging.⁵⁹⁻⁶¹ Exposure to chronic stress, particularly in childhood, can also influence a person's





ability to cope effectively with stressors later in life.⁶²⁻⁶⁴ Early life adversity or abuse can cause long-term changes in the brain itself, in regions crucial to memory, learning and self-regulation.²⁷

- **Violence can influence health through its impact on social and economic conditions in communities.** At the neighborhood and community level, violence can lead to widespread feelings of fear, distrust and isolation, which in turn can contribute to diminished levels of health-promoting social support and social cohesion. Residents of communities where violence frequently occurs may be less likely to exercise and to use community resources like parks and playgrounds that would otherwise promote both healthy behaviors and social interaction. Conversely, strong social networks and cohesion in communities may contribute to community norms that support healthier behaviors and discourage violence. Violence can also act as an obstacle to investments in health-promoting community resources and opportunities for residents. For example, companies may be less likely to operate full-service supermarkets in neighborhoods where violence is prevalent, contributing to the creation of “food deserts” where residents have few options for purchasing fresh foods. These violence-related disincentives for investment in communities also affect the availability of jobs, thus contributing to higher levels of economic and social disadvantage that in turn can foster violence.⁶⁵

Strong social networks and cohesion in communities may contribute to community norms that support healthier behaviors and discourage violence.

4. The links between violence and social disadvantage

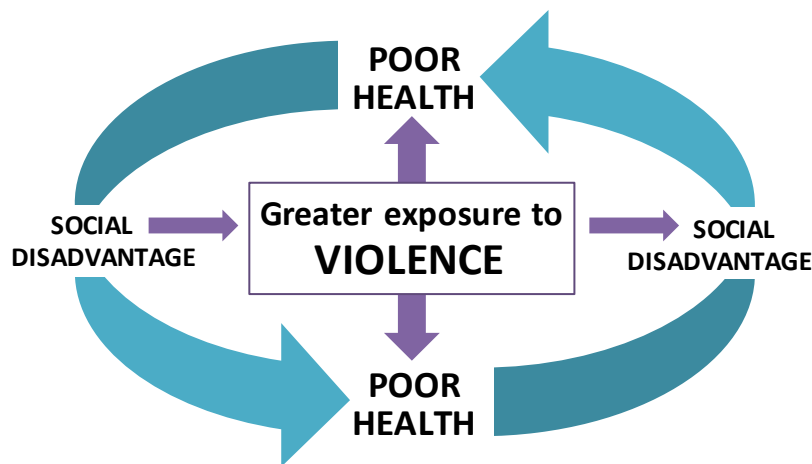


Figure 2. The links between violence and social disadvantage.

Pathways linking violence and social disadvantage are illustrated in Figure 2. Social advantage or disadvantage refers to the relatively favorable or unfavorable conditions that people experience related to differences in social and economic resources and opportunities tied to factors such as income and wealth, education and occupation. As discussed below, greater social disadvantage increases the likelihood that a person will be exposed to violence—directly and/or indirectly—in his or her family or community. Violence, and poorer health as a result of direct or indirect exposure to violence, in turn can exacerbate social disadvantage, both for the individuals who experience violence as victims or witnesses and for the communities in which they live.





SOCIAL DISADVANTAGE INCREASES A PERSON'S LIKELIHOOD OF EXPOSURE TO VIOLENCE

As noted earlier, routinely-collected data on violence often lack information on socioeconomic factors such as income or education. Based on the evidence from the limited number of studies that have included such information, however, it is clear that—although violence occurs across the socioeconomic continuum—the risks of exposure to violence are greatest for people in the most socioeconomically disadvantaged groups and communities. For example:

- Children in low socioeconomic status households (with yearly incomes below \$15,000, with parents who were not high school graduates, or with at least one family member receiving some form of public assistance) were more than five times as likely as other children to experience maltreatment.⁶⁶
- Families experiencing unemployment or under-employment are at particular risk for intimate partner violence.⁶⁷
- Persons with low educational attainment and those who are unemployed are at increased risk of death from homicide.⁶⁸

Some studies have found that residents in socially disadvantaged communities are at greater risk of experiencing violence, even after considering their own individual-level socioeconomic characteristics:

- White and black women who live in poor U.S. neighborhoods are more likely to experience intimate partner violence, taking into account individual-level characteristics such as household income, educational attainment, employment and marital status, number of children and alcohol use.⁶⁹
- Rates of assault injuries among non-elderly adults increase with increasing levels of neighborhood deprivation, measured using a multi-item index (Figure 3).⁷⁰
- Residents of neighborhoods with low family incomes, high poverty, high proportions of residents who had not completed high school, and low housing values were at increased risk of death from homicide, again taking their own individual socioeconomic characteristics into account (Figure 4).⁶⁸
- In a 2006 review, all 24 studies of economic inequality and homicide rates in large areas (entire countries, regions, states or cities) reported significant relationships between the extent of income inequality and homicide rates.⁷¹

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DISTRIBUTION OF HOSPITALIZATIONS FOR ASSAULT-RELATED INJURIES, BY NEIGHBORHOOD SOCIOECONOMIC STATUS

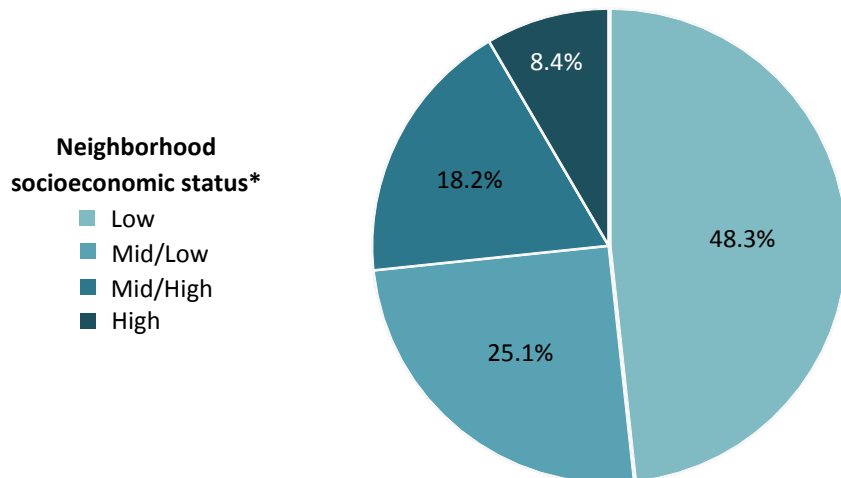


Figure 3. Living in a disadvantaged neighborhood increases the likelihood of being a victim of violence.

*Assessed using the Vancouver Area Neighborhood Deprivation Index. Source: Bell et al. Can J Public Health 2009.

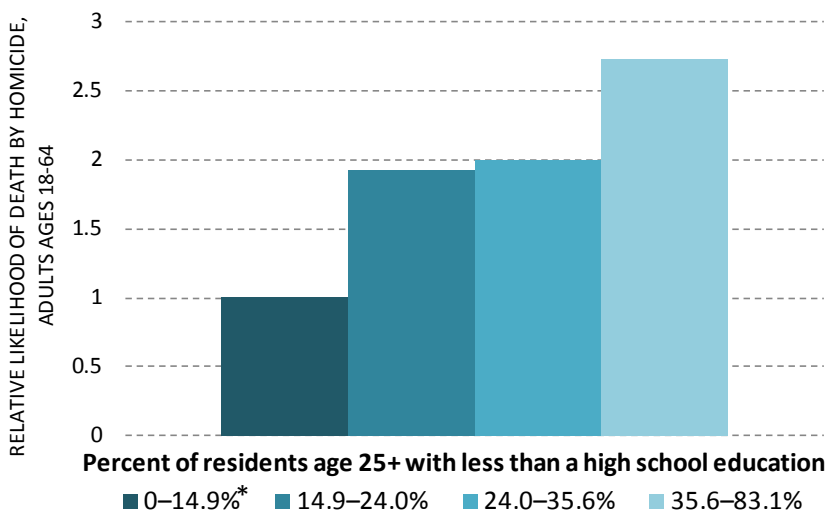


Figure 4. Risks of homicide increase with increasing proportions of neighborhood residents who have not completed high school.

*Reference group. Adjusted for individual demographic and socioeconomic characteristics. Source: Cubbin et al. J Epidemiol Community Health 2000.





What might explain the links between social disadvantage and increased risks of violence? Individuals who have more limited economic and social resources experience greater levels of chronic stress in their everyday lives, because of the strain of having to face everyday challenges with inadequate resources (see the “Stress and Health” issue brief in this series).⁷² At the same time, their social networks are more likely to include others with limited resources who are less able to provide material or emotional support. Social disorganization, which is more prevalent in economically disadvantaged communities, is thought to be an important contributor to violence.⁷³ These conditions may deepen the feelings of anger, frustration and hopelessness that may make people more likely to resort to violence in situations of conflict. Because peer norms are particularly influential in shaping behaviors among youth, young people living in communities where violence is prevalent may be even more likely to engage in violent behaviors themselves.

Aspects of the physical and built environment may also contribute to the prevalence of violence in poor neighborhoods. For example, one study found that the level of ‘physical disorder’ (based on observations of litter, graffiti and abandoned cars) in Pittsburgh, PA, neighborhoods corresponded to levels of crime and firearm injuries or deaths, even after taking neighborhood poverty levels into account.⁷⁴ Other research has linked changing rates of assault and intimate partner violence in neighborhoods with increasing or decreasing access to alcohol sales, after considering other area- and individual-level characteristics.⁷⁵⁻⁷⁷

VIOLENCE IN TURN CAN LEAD TO GREATER SOCIAL DISADVANTAGE

While current knowledge supports the role of social disadvantage as a contributor to violence, we also know that violence in turn can lead to greater social disadvantage, both for individuals and communities. For example, children and youth exposed to violence are more likely to have poor educational outcomes and lower educational attainment, which in turn can limit their opportunities for future employment and employment-related income (see the “Education and Health” issue brief in this series).⁷⁸⁻⁸¹ Violence can have negative impacts on social and economic resources and opportunities at the community level as well; for example, concerns about violence and safety may discourage business from locating and investing in low-income neighborhoods, further reducing services and employment opportunities.





RACIAL OR ETHNIC DIFFERENCES IN VIOLENT CRIME REFLECT SOCIAL DISADVANTAGE, WHICH IS RARELY MEASURED

Historically in the United States, routinely-collected data on violence have been reported by race or ethnic group, without additional breakdown by socioeconomic factors such as education or income. As seen in Figure 5, for example, rates of homicide vary dramatically by race or ethnic group—particularly among youths and young adults. What explains these differences?

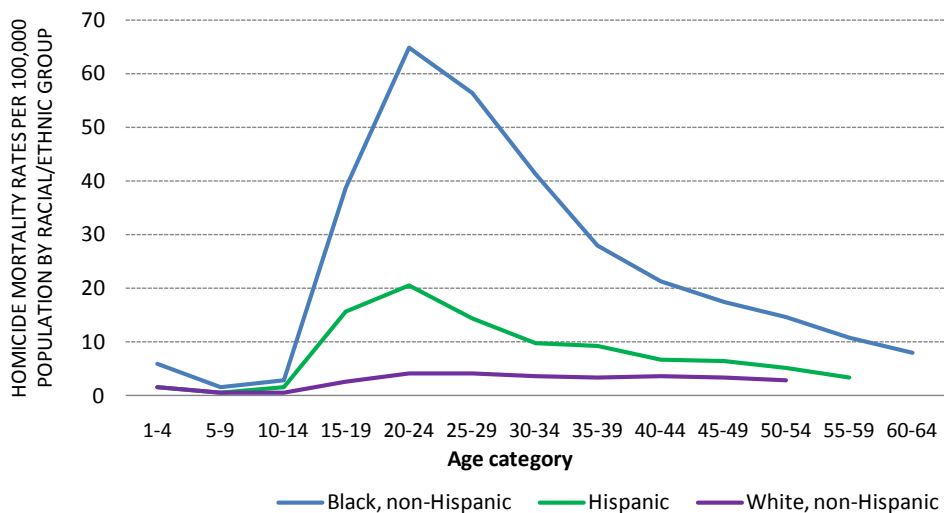


Figure 5. Rates of homicide vary dramatically by race or ethnic group, particularly among youth and young adults.

Source: CDC/NCHS, National Vital Statistics System

Data on income and education clearly demonstrate that African Americans (blacks), American Indians, Hispanics, Pacific Islanders and some Asian groups are disproportionately represented among the more socioeconomically disadvantaged groups in the United States.⁸²⁻⁸⁶ Even at similar income levels, blacks and Hispanics are more likely than whites to live in neighborhoods with concentrated disadvantage.⁸⁷⁻⁸⁹ This socioeconomic inequality reflects a long history of racial inequality in which racial or ethnic background was, until the Civil Rights Act of 1964, legally used to exclude individuals from employment, educational opportunities, property ownership and residential locations. Although most explicit uses of race to demean or exclude people from participation in society have been outlawed, racial residential segregation persists. This legacy, along with subtle institutional forms of bias that limit economic and social opportunities, continues to shape living and working conditions—and related exposure to violence and its health effects—for many people of color (see the “Race, Socioeconomic Factors and Health” issue brief in this series).

Studies that have taken into account differences in at least one socioeconomic measure (such as education, income, residential location, crowding or measures of neighborhood disadvantage) have found that the observed racial/ethnic differences in violence (in these studies, intimate partner violence or homicide and youth homicide) were greatly reduced or eliminated.^{67, 90-92} For example, a recent study of injury admissions to Pennsylvania hospitals found links between racial segregation at the county level and increased risk of violent injury, after considering other individual and county-level risk characteristics.⁹³ Differences in other important socioeconomic factors that are typically unmeasured—including accumulated wealth, neighborhood socioeconomic characteristics, and socioeconomic circumstances during childhood⁹⁴—are also likely to explain the racial/ethnic patterns of violence.⁹⁵

When considering reported racial/ethnic differences in rates of violence, it is also important to be aware of considerable evidence that blacks receive more severe sentences than whites for similar offenses, even after taking prior criminal history into account.⁹⁶ Differences in rates of incarceration in turn contribute profoundly to racial/ethnic differences in social advantage. The combination of incarceration and poorly supported re-entry “disrupts the social networks that are the basis of informal social control.”⁹⁷ Residents of disadvantaged neighborhoods in U.S. inner cities include a “growing number of men, mostly non-White, who become unskilled petty criminals because of no avenues to a viable, satisfying, conventional life.”⁹⁸





5. Strategies to prevent violence through a social determinants framework

There is widespread agreement that efforts to reduce the tragic health impacts of violence must focus on preventing violence before it occurs. Reflecting the growing awareness of the important links between social factors and violence, the Division of Violence Prevention at the Centers for Disease Control and Prevention promotes a *social-ecological model* for violence prevention (Figure 6).⁹⁹ Originally proposed by Dahlberg and Krug,¹⁰⁰ this model focuses on prevention strategies that address risk factors for violence across four inter-related levels—calling attention to the need for efforts that address the more fundamental sources of violence at the societal level, in addition to more traditional efforts focused on reducing risky individual behaviors.

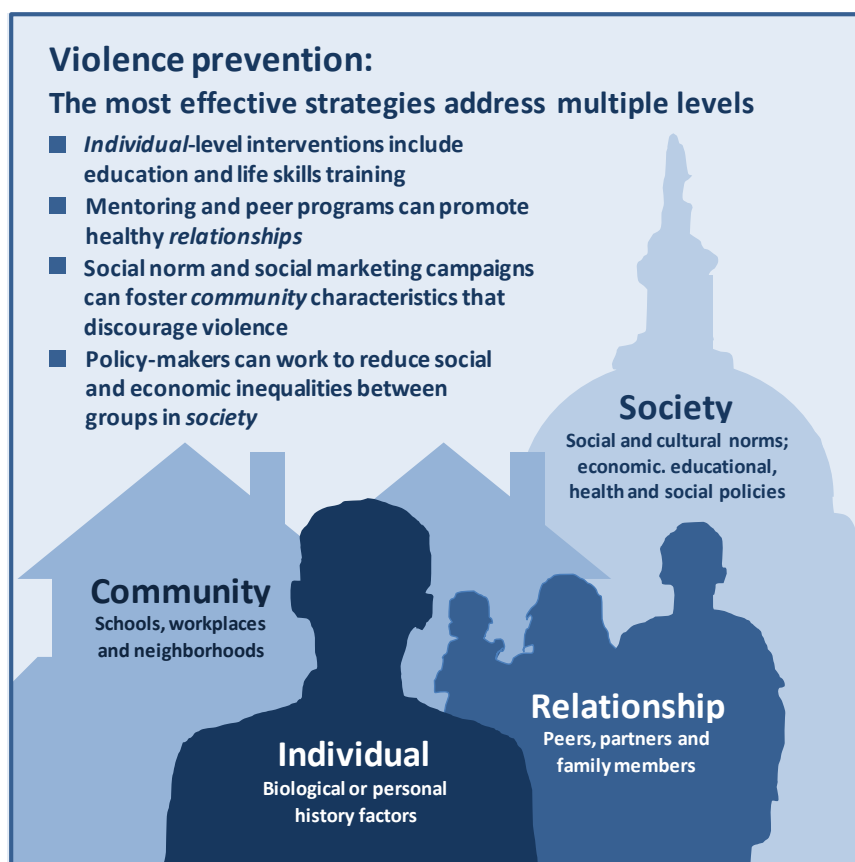


Figure 6. The social-ecological model for violence prevention.

Adapted from *Violence Prevention—The Social-Ecological Model: A Framework for Prevention*. Centers for Disease Control and Prevention.

- *Individual.* Individual-level characteristics that reflect a person’s risk for becoming a victim or perpetrator of violence include low levels of educational attainment and income, and history of abuse and behaviors such as substance use. Typical individual-level approaches have included life-skills training, focused on promoting risk-reducing attitudes, beliefs and behaviors.





- *Relationship.* Because a person’s relationships within the family and broader community may also influence his or her risks of experiencing violence as a victim or perpetrator, prevention strategies at this level focus on promoting healthy relationships and building conflict-resolution and problem-solving skills through approaches like mentoring, peer support programs, and family counseling services.
- *Community.* This level of prevention focuses on addressing the conditions in schools, workplaces and neighborhoods that increase the risks of violence. Approaches include social marketing campaigns designed to “foster community climates that promote healthy relationships.”
- *Societal.* Societal-level approaches to preventing violence focus more broadly on both the fundamental conditions that foster violence and the policies that shape them. Such approaches would, for example, address social disadvantage and how its damaging effects can be ameliorated through social policies focusing on early child development programs; job training, counseling and creation; community economic development in low-income communities; increasing educational quality, attainment and opportunity; poverty reduction; and other social policy approaches.

The following are some examples of promising strategies to prevent violence and its adverse health effects by addressing the social factors that shape them:

- Preventing child maltreatment and intimate partner violence (IPV) is crucial for interrupting the cycle of violence. Some home-visitation programs have provided high-risk expectant and new mothers with visits from trained professionals who teach parenting skills, encourage healthy behaviors, and provide links to services. These programs have found lower rates of child maltreatment, as well as IPV victimization and perpetration, among participants compared with families in the control group.^{101, 102}
- High-quality center-based early childhood development programs have also been shown to result in marked reductions in criminal involvement decades later (see the “Early Childhood Experiences and Health” issue brief in this series). Several comprehensive early childhood education programs targeting low-income preschoolers and their parents have shown effects on violent behavior in participants even into adulthood. Children who attended the High Scope/Perry Preschool Project and the Chicago Child-Parent Center—which emphasized a participatory, individualized learning approach and parent involvement—were less likely to be arrested for felonies or violent crimes or incarcerated as adults than comparable children who did not attend the programs.¹⁰³
- School violence prevention is often approached in terms of enhanced security measures rather than as part of a public health strategy to prevent violence before it occurs. In addition to the individual-level programs described above, promising strategies include those that foster student, family and community engagement, a sense of school connectedness among students, positive adult support and classroom management techniques that respond to students’ diverse cognitive, emotional and social needs.¹⁰⁴





- The U.S. Task Force on Community Preventive Services strongly recommends universal, school-based programs for preventing or reducing violent behavior. Programs meeting certain criteria appeared to be effective at all grade levels, from pre-kindergarten to high school, and in diverse school and community environments.¹⁰⁵
- The Wraparound Project at the University of California, San Francisco, is a successful hospital-based model in which case managers see victims of interpersonal/youth violence from 14-25 years of age while they recover from physical injury. Based on the idea that suffering a sudden change of health status may create a window of time in which young people caught in the cycle of violence may be more receptive to change, the program facilitates access to an array of services and resources targeting improvement in the employment, education, mental health and social risk factors that contribute to involvement in youth violence.¹⁰⁶
- In Salinas, CA, broad coalitions including non-traditional partners developed a framework and succeeded in obtaining funding for local groups and projects addressing 12 key areas including literacy, jobs and parental participation in schools. Minneapolis, MN, took a public-health approach to building resilience and changing norms in individuals and neighborhoods. In both cities, rates of violence dropped after these comprehensive plans were implemented. A report from The Prevention Institute, “Addressing the Intersection,” describes many programs that have been implemented in diverse settings.⁶⁵
- Homeboy Industries was founded in Los Angeles, CA, by Father Gregory J. Boyle, who serves on the advisory boards for the Loyola Law School Center for Juvenile Law and Policy and the National Gang Center and was a member of the California State Commission on Juvenile Justice, Crime and Delinquency Prevention. The organization helps gang members, those recently released from detention facilities, and other at-risk youth find assistance with job training and placement, tattoo removal, counseling, community service opportunities and case-management services. The Homeboy Industries motto is “Nothing stops a bullet like a job.”¹⁰⁷
- The Prevention Institute’s UNITY (Urban Networks to Increase Thriving Youth through Violence Prevention) project, funded by the Centers for Disease Control and Prevention, released a summary in 2010 of the UNITY “Urban Agenda for Preventing Violence Before it Occurs.” The policy platform recommends a multi-faceted approach that involves many sectors and includes high-level leadership and community engagement in planning and implementation. Strategies include street outreach, treatment of mental health problems and substance abuse, and enhancement of protective factors among youth in neighborhoods with high levels of violence, along with community capacity-building through social connections and collective skill-building and problem solving; economic development and high-quality education and early care; and efforts at the state and federal levels to increase resources, multi-sector collaboration, communications campaigns and public-health capacity and infrastructure.¹⁰⁸





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ABOUT THIS ISSUE BRIEF SERIES

This issue brief is one in a series of ten on the social determinants of health. The series began as a product of the Robert Wood Johnson Foundation Commission to Build a Healthier America and continues as a part of the Foundation's Vulnerable Populations portfolio. www.rwjf.org/vulnerablepopulations

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