A Literature Review on Cultural Competency Related to Quality Services for African Americans

Prepared for the Institute on Domestic Violence in the African American Community (IDVAAC)

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Executive Summary

Cultural competency has been defined as "a set of congruent behaviors, attitudes and policies that come together in a system, agency and among professionals that enables effective work in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989). To effectively respond to domestic and other gender-based violence, services must be tailored to address diverse communities' needs, resources, values, preferences, and overall cultural context. In an effort to ensure effective, quality domestic violence prevention and intervention services and supports for African Americans, the Institute on Domestic Violence in the African American Community (IDVAAC) research team conducted a search of literature on the definitions and evolution of culture- and cultural competency-related terms as well as how these terms are used in serving African American communities. The purposes of the literature review project were to:

1) Examine research that provides context on recommended frameworks and best practices for serving African American communities affected by domestic violence;
2) Determine recommended language for the domestic violence prevention and intervention field to help conceptualize cultural competency; and
3) Provide guidance for how to work effectively with African American communities.

The literature review consisted of a targeted search of published peer-reviewed literature as well as government and foundation reports related to race; ethnicity; culturally specific populations and services; culturally competent, responsive, and relevant interventions, services, programs, and organizations, particularly related to domestic violence and sexual assault. With the exception of seminal articles, the literature review included articles from 2000 to present. The academic literature was located through bibliographic search engines; resources also were identified through the sources referenced in the initially reviewed documents and through recommendations of the expert reviewers. The annotated bibliography was organized by the key topic areas and domains related to cultural competency, highlighting literature pertaining to domestic violence and sexual assault. In addition to a summary of relevant literature for each topic area, the annotated bibliography discussed insights, common themes, and lessons learned from literature; remaining gaps in literature; and recommendations for future research and practice are provided to enhance quality and accessibility of domestic violence interventions for African Americans.

The purpose of this annotated bibliography is to explore complex issues and concepts relevant to domestic violence in African American communities to advance the field and elucidate best practices in addressing domestic violence in a culturally relevant manner. The reviewed literature underscored the fact that "one-size-fits-all" approaches to domestic violence services do not effectively support African American communities. The review of extant research to inform the development and implementation of evidence-informed, tailored, culturally responsive domestic violence interventions for African Americans revealed a number of key insights as well as research and practice needs.

Insights from Existing Literature and Themes Related to Cultural Competency

Existing literature revealed a number of themes related to cultural competency. First, although there was a lack of consensus in terminology to conceptualize cultural competency, existing research has moved from an individual focus on cultural competency development to a

multilevel focus that includes accountability and best practices at the individual to systems and community levels to address barriers to adequate care. Additionally, cultural competency is viewed as a journey rather than a destination, allowing for ongoing development of practices and procedures to provide quality care to diverse populations. Best practices include providers' cultural flexibility and responsiveness; ongoing self-reflection and examination; thorough understanding of social and cultural contexts; culturally diverse providers that reflect the populations served; engaging natural supports; integrating cultural competency into organizational values and mission, policies and procedures, governance, planning, and infrastructure of organizations; ongoing training and professional development of providers; systematic evaluation of cultural competency, effectiveness of interventions, and quality of care to diverse populations; and integrating cultural competency into all existing health-related systems(e.g., Anderson et al., 2003; Betancourt et al., 2002; Betancourt et al., 2003; Ferguson & Candib, 2002; Napoles-Springer et al., 2005; Resnicow et al., 1999; Sullivan, 2012; Wilson-Stronks et al., 2008).

Second, the expanded focus on cultural competency suggests community buy-in and public demand to provide quality services to diverse populations (e.g., Goode et al., 2006; Wu & Martinez, 2006). The evolution from individual- to system-level cultural competency and an emphasis on an understanding of intersecting factors that are particularly relevant for individuals who have experienced domestic and gender-based violence indicate an expanded concept of responsibility to provide high quality, effective domestic violence services and supports to diverse communities. This expanded responsibility includes increasing engagement of community supports and natural helpers including faith- and culture-based organizations (e.g., Brade & Bent-Goodley, 2009; Gillum, 2009; Williams, 2007). It also is critical to engage individuals experiencing domestic violence as partners, empowering them in solutions to address domestic violence and ensure a continuum of domestic violence prevention and intervention resources for African Americans (e.g., West & Johnson, 2003; Williams, 2007).

Third, culturally specific and tailored interventions and curricula consider culture-specific values, norms, attitudes, expectations, and customs of the populations served. Principles of quality in domestic violence services include safety, equity, effectiveness, and client-centeredness and partnership. These considerations and principles are particularly relevant for African American communities to develop strategies that are safe, comfortable, relevant, and respectful; that recognize potential feelings of mistrust toward formal social services; incorporate the intersectionality of complex factors that can affect domestic violence; and are strengths-based. In addition to expertise in violence and trauma, empathy, connection, rapport, and in-depth appreciation of historical and contemporary experiences are critical in culturally sensitive domestic violence interventions for African Americans (e.g., Betancourt, 2006; Ferguson & Candib, 2002; Gillum, 2009; Johnson et al., 2004; Napoles-Springer, 2005; Sullivan, 2012; West & Johnson, 2003; Williams, 2007).

Gaps in the Literature

The reviewed literature identified and intended to fill gaps related to continued barriers to supports for survivors of domestic and gender-based violence, research, and practice. Further research is needed on the barriers to accessible and culturally responsive services, particularly for certain communities. More research and strengths-based holistic health

supports are needed for African American women who have histories of sexual assault and other trauma, incarcerated women, and women from under-resourced communities. Other special populations and needs include formerly incarcerated men, people living with HIV/AIDS, rural or geographically and socially isolated communities, and lesbian, gay, bisexual, and transgender (LGBT) communities. More research on child maltreatment, children's exposure to violence, and the efficacy of domestic violence services on children's well-being also is recommended.

Further research is needed to thoroughly understand the intersectionality of individual to sociocultural factors and health outcomes. Such research includes examinations of racial, ethnic, and socioeconomic disparities; definitions and measures of multilevel cultural and linguistic competence; and the effectiveness of cultural competency strategies and interventions in improving health outcomes and responding to domestic violence. More reliable and high quality data related to race, ethnicity, and other sociodemographic factors also are necessary to thoroughly understand the intersection of factors related to violence in African American communities.

Additionally, further development of practice is required to fill gaps in quality and culturally responsive care. Current research recommends development of community-based services that consider issues such as poverty, racism and discrimination, and service accessibility. As many existing domestic violence services are mainstream and not culturally-specific or culturally-focused, ongoing research is needed on interventions designed for African Americans and other communities of color to determine their effectiveness. Further examinations of the role of faith and faith-based and community leaders in supportive services are needed given the importance of natural supports and the faith community in addressing domestic violence.

Recommendations for Future Directions and Quality Services for African Americans

Based on the existing literature, a number of strategies are recommended to ensure the availability of the highest quality and most effective domestic violence services and supports for Black/African American communities. Future directions must entail evidence-, culturally-, trauma-, and survivor-informed approaches; appreciation of diversity; and attention to the interrelationship of complex factors that African Americans have experienced that may influence their resources and opportunities as well as both domestic violence and healthy relationships.

Understanding and conceptualization of cultural factors

- Increase the understanding in the field of people's racial, ethnic, and cultural identities and their interpretation of what membership in these groups represents for them.
- Increase understanding of the diversity within African Americans communities and strategies to tailor interventions to the needs and strengths of populations within the African American community to best serve them.
- Encourage providers' understanding and reflection of how their own values and norms may contrast with service recipients and affect care.

- Increase understanding of negative and positive experiences that may affect African Americans seeking and receiving domestic violence services, sharing their experiences, or participating in research.
- Develop validated and shared definitions and frameworks of cultural competence and expand conceptualizations of culture (e.g., beyond race, ethnicity, or language).

Evidence-informed services

- Treat service recipients as equal partners in their care to ensure culturally responsive and tailored services.
- Consider the balance between fidelity to evidence-based practices and culturally-specific and culturally-focused adaptations to provide quality care to diverse populations.
- Include organizational, structural, clinical, and systemic cultural competency approaches to reduce multilevel barriers to quality care.
- Create policies, procedures, accountability measures, and leverage resources to infuse ongoing cultural competency development and sustainability.

Research and data

- Enhance the quality, reliability, completeness, and availability of data on racially, ethnically, and linguistically diverse populations.
- Collect and use community- and service recipient-level data to measure, monitor, and evaluate the quality, effectiveness, and utilization of culturally responsive services.
- Conduct longitudinal and large sample studies to determine the short- and long-term effects of culturally competent services on health and well-being.
- Research interactions among factors that can affect individuals' health, experiences, behaviors, and resources to inform cultural responsive interventions.
- Continue to thoroughly examine the unique strengths, needs, historical contexts, and relationships of the diverse communities within the African American population and expand research on diverse communities to increase representativeness and generalizability.
- When delivering services, address issues that intersect with domestic and sexual violence among African Americans, including health disparities, historical trauma, spirituality, and community support.

Community involvement and response

- Build multisector partnerships in the community to advance culturally responsive services to African American communities.
- Consider cost savings and implications in safe, quality culturally responsive care to build the business case for culturally responsive services, programs, and organizations.
- Involve community members and service recipients in every aspect of care.
- Seek leaders of community groups to solicit concerns and recommendations about responsive, high quality domestic violence services for diverse populations.
- Engage and equip trusted community and faith leaders and organizations to provide domestic violence support services.

- Engage diverse stakeholders including practitioners, researchers, policymakers, educators, activists, families experiencing domestic violence, community- and faith-based organizations, and the larger community to serve as advocates to prevent domestic violence.

The literature in this annotated bibliography can provide guidance to most effectively respond to and work to prevent domestic violence in African American/Black communities. The review of literature can inform the development of culturally responsive and appropriate domestic violence prevention and intervention efforts. The annotated bibliography is useful for multisector providers, researchers, policymakers, advocates, community- and faith-based organizations and groups, community members, and other stakeholders to increase understanding of factors related to domestic violence in African American communities and responses to end violence. This report promotes the evidence-based, culturally competent, trauma-informed, and survivor-informed approaches that are vital to promoting the health of African Americans and working towards ending domestic violence.

1. Introduction

Cultural competency has been defined as "a set of congruent behaviors, attitudes and policies that come together in a system, agency and among professionals that enables effective work in cross-cultural situations."[1,2] The Institute on Domestic Violence in the African American Community (IDVAAC) works to increase the understanding and capacity of providers, researchers, policymakers, organizations, and communities to contribute to domestic violence services and supports that are relevant to culturally diverse individuals. To effectively respond to domestic and other gender-based violence, services must be tailored to address diverse communities' needs, resources, values, preferences, and overall cultural context.

Further research on culturally competent approaches is necessary to ensure effective, quality services and supports and to improve outcomes of African American service recipients. The purposes of this literature review project, therefore, are to:

1) Examine research that provides context on recommended frameworks and best practices for serving African American communities affected by domestic violence;
2) Determine recommended language for the domestic violence prevention and intervention field to help conceptualize cultural competency; and
3) Provide guidance for how to work effectively with African American communities.

About this Literature Review

To inform quality domestic violence prevention and intervention services for African American populations, the IDVAAC research team (consisting of a research assistant, consultant, and expert reviewers) conducted a search of literature on the definitions and evolution of culture- and cultural competency-related terms as well as how these terms are used in serving African American communities. The research team searched the following concepts and terms:

- Race and ethnicity relative to African American/Black
- Culturally specific populations
- Culturally specific services, programs, and interventions
- Cultural competency/competence
- Culturally competent programs/organizations
- Culturally competent/relevant/responsive services and interventions

Domestic violence, sexual assault, evidence-based practice, and trauma-informed care issues related to the aforementioned concepts were explored.

The literature review consisted of a targeted search of published peer-reviewed literature as well as government and foundation reports related to the aforementioned terms. With the exception of seminal articles, the literature review included articles from 2000 to

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[1] Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a Culturally Competent System of Care, Volume I.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

[2] What is cultural competency? U. S. Department of Health and Human Services Office of Minority Health Website. http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11.

present. The academic literature was located through bibliographic search engines PubMed and Web of Science, as well as through Google Scholar. Additionally, articles, books, reports, and online resources were identified through the sources referenced in the initially reviewed documents and through recommendations of the expert reviewers. Table 1 summarizes the inclusion criteria for the sources.

Table 1. Literature Review Inclusion Criteria

Inclusion Criteria	Low Priority/Exclusion Criteria
• **Publication years:** 2000 to present, unless indicated as a seminal study • **Research design/source type:** Empirical research, meta-analyses, systematic reviews of literature, non-systematic reviews, reports • **Populations:** Black/African American communities; racially/ethnically diverse communities • **Topics:** Culturally competent, relevant, and specific services and approaches for people of African descent	• **Publication years:** Earlier than 2000, unless seminal or particularly relevant to current study • **Research design/source type:** Editorials; letters; comment/opinion; abstracts only • **Populations:** Non-African American/Black communities, unless in the context of culturally-specific services and best practices • **Topics:** Research not related to culturally competent services for diverse populations or to address domestic violence

The following annotated bibliography is organized by the key topic areas and domains related to cultural competency. Within these areas, citations may be listed under subsections that describe the emphasis of the material. Literature pertaining to sexual assault and domestic violence are highlighted in subsections of the cultural competency sections. Each section begins with an overview of the topic/concept. Relevant literature that meets the aforementioned inclusion criteria are then summarized. The annotated bibliography ends with insights, common themes, and lessons learned from literature regarding culturally competent domestic violence-related services and support for African Americans. Remaining gaps in literature are discussed to guide future directions in research and continued service improvements for African American communities. Recommendations for future research and practice are provided to enhance quality and accessibility of services.

The purpose of this annotated bibliography is to explore complex issues and concepts relevant to domestic violence in African American communities to advance the field. Defining cultural competency and related concepts can help elucidate best practices in quality service provision for domestic and gender-based violence in African American communities as well as gaps in literature to guide future research and practice efforts. This review can inform the development of culturally responsive and appropriate domestic violence services, curricula, research, training and education, and other prevention and intervention efforts. The annotated bibliography is useful for multisector providers, researchers, policymakers, advocates, community- and faith-based organizations and groups, community members, and other stakeholders to increase understanding of factors related to domestic violence in African American communities and responses to end violence. This report promotes the culturally competent, evidence-based, trauma-informed, and survivor-informed approaches that are vital to effectively address domestic violence in African American communities, with the ultimate goal of ending violence and further promoting the health and well-being of African Americans.

2. Race and Ethnicity

Race has been defined as a cultural construct used to explain perceived biological differences among humans, and ethnicity is a social and cultural construct used to define social boundaries, differentiate individuals, and assign identity to members of a group on the basis of factors associated with ancestry and traditions.[3] Historical and social context, cultures, and structural barriers related to race and ethnicity affect individuals' experiences. This understanding and sensitivity to the experiences, resources, and needs of African Americans can increase awareness of providers' and community members' perspectives, improve interactions and relationships, increase understanding of factors that influence health, and help guide appropriate, equitable services.

2.1 Racial and Ethnic Diversity

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13,* 181-184.

This article presents cultural competence as an ongoing process for the health care provider, which consists of cultural awareness, knowledge, skill, encounters, and desire. The author emphasizes that there is greater heterogeneity within ethnic groups than across ethnic groups and that level of cultural competence is directly related to the ability to provide effective, culturally responsive services.

Ferguson, W. J., & Candib, L. M. (2002). Culture, language and the doctor-patient relationship. *Family Medicine, 34,* 353-361.

This literature review examines patient-provider relationships and communication to determine how race, ethnicity, and language influence the quality of the relationship. Studies on patients with limited English proficiency (LEP), patient preference, rapport and relationship building, and physician bias were reviewed. Studies found that race, ethnicity, and language influence the quality of doctor-patient relationships. Doctors of African American and Hispanic/Latino patients and individuals with LEP were less likely to express empathy, establish rapport, or provide sufficient information and encouragement to patients to participate in medical decision making. African American and Hispanic/Latino patients were more likely to choose providers of the same race, ethnicity, or language and feel connected to and involved in decision making with these providers.

National Committee on Vital and Health Statistics (NCVHS) (2005). *Eliminating health disparities: Strengthening data on race, ethnicity and primary language in the United States.* Washington, DC: NCVHS. Retrieved from http://www.ncvhs.hhs.gov/051107rpt.pdf

This report summarizes the NCVHS findings and recommendations for the U.S. Department of Health and Human Services and its partners on collecting data on race, ethnicity, and primary language. The report recommends enhancing: 1) data quality, reliability, and completeness;

[3] Dressler, W. W., Oths, K. S., & Gravlee, C.C. (2005). Race and ethnicity in public health research: Models to explain health disparities. *Annual Review of Anthropology, 34,* 231-252.

and 2) the capacity of health statistics infrastructure to analyze, report, and disseminate data on racially, ethnically, and linguistically diverse populations.

Sellers, R. M., Smith, M. A., Shelton, J. N., Rowley, S. A., & Chavous, T. M. (1998). Multidimensional model of racial identity: A reconceptualization of African American racial identity. *Personality and Social Psychology Review, 2*, 18-39.

The Multidimensional Model of Racial Identity (MMRI) defines racial identity as a component of an individual's self-concept related to her/his membership within a race. Racial identity entails the significance individuals place on race as part of their self-definition and their interpretations of what it means to be Black/African American. The MMRI proposes four dimensions of racial identity in African Americans: 1) salience of the identity (self-definition); 2) centrality of the identity (self-definition); 3) ideology associated with the identity (qualitative meaning); and 4) regard in which the person holds African Americans (qualitative meaning). The MMRI represents a synthesis of ideas from several existing models of African American racial identity.

Domestic Violence- and Sexual Assault-Related Studies

Bent-Goodley, T. B., & Williams, O. J. (2003). *Community insights on domestic violence among African Americans: Conversations about domestic violence and other issues affecting their community.* St. Paul, MN: IDVAAC.

This report on perceptions of domestic violence among African Americans living in Detroit, MI aims to increase understanding of the unique experiences of African Americans and identify solutions to address domestic violence in African American communities. Focus groups were conducted with stakeholders in the African American community to discuss types of violence in the community, causes and consequences of intimate partner violence (IPV), and barriers and solutions to addressing IPV. The participants comprised children and youth services representatives; human services representatives; community activists; members of the faith community; lesbian, gay, bisexual, and transgender (LGBT) advocates; and law enforcement representatives. Focus group participants indicated that: discrimination and historical context are key factors in understanding IPV in the African American community; community stressors, limited resources, rigid gender roles and gender role socialization, and family histories of violence negatively affect relationships and influence domestic violence; given its unique role in the community, the church should be further trained and involved in domestic violence interventions; and comprehensive, culturally appropriate, and community-based responses to domestic violence are necessary. The findings are useful for practitioners, policymakers, and other stakeholders to increase understanding of the perspectives of African American communities around domestic violence and inform solutions to domestic violence.

Bent-Goodley, T. B., & Williams, O. J. (2004). *Community insights on domestic violence among African Americans: Conversations about domestic violence and other issues affecting their community.* St. Paul, MN: IDVAAC.

This report on perceptions of domestic violence among African Americans living in Seattle, WA

aims to 1) inform a broad audience about the intricacies of domestic violence in the lives of African Americans and 2) identify solutions to address domestic violence within African American communities. Gaps in the literature include insufficient substantive information about the causes and consequences of domestic violence in the African American community; limited exploration of the convergence of race, socioeconomic status, and other factors in understanding the prevalence of domestic violence among African Americans; and inadequate understanding of African Americans' experiences with domestic violence (e.g., concerns around the greater good and protecting their partners from consequences that influence some African American women's decisions about reporting abuse). Affinity groups were conducted with the following community representatives: child and youth workers; activists; members of the faith community; LGBT advocates; human services representatives; and law enforcement representatives. The focus groups findings revealed that: domestic violence is pervasive and connected to other forms of violence; racism and discrimination impact domestic violence in the African American community; lack of community cohesion, inadequate resources and funding, and competition were barriers to effectively addressing domestic violence; and holistic, comprehensive, and culturally-based solutions to domestic violence are recommended to best support the African American community. The report informs practitioners on culturally-based prevention and interventions, strengths-based services, and trainings. The report offers recommendations for policymakers to reducing domestic violence through increased funding, services, and policies. Additional research on racism, oppression, discrimination, differential treatment of African Americans in law enforcement and child welfare systems, and culturally competent domestic violence prevention and intervention models is recommended.

Ward Griffin, L., & Williams, O. J. (2005). ***Community insights on domestic violence among African Americans: Conversations about domestic violence and other issues affecting their community.*** **St. Paul, MN: IDVAAC.**

This report on perceptions of domestic violence among African Americans living in Memphis, TN aims to increase service providers', criminal justice practitioners', public officials', and other stakeholders' understanding of the experiences, causes, and consequences of domestic violence in African American communities and potential strategies to prevent domestic violence. To add to the evolving literature on domestic violence among African Americans, community assessment sessions were conducted with the following community stakeholders: child and youth workers; members of the faith community; human services representatives; and law enforcement representatives. Participants in the community assessment sessions suggested that: violence is pervasive in all communities and domestic violence is connected to other forms of violence; because African Americans' definition of domestic violence may differ from traditional definitions, proposed methods to end violence must be tailored to African Americans; violence among African American youth reflects a need for social and economic respect; desegregation has contributed to a loss of community and family cohesion; lack of funding and competition are barriers to addressing domestic violence; and community awareness campaigns, breaking the "code of silence," and systematic, comprehensive, culturally based interventions are needed to address domestic violence in the local African American community. The report informs practitioners on the need for more community cohesion; accessible, culturally-based prevention and intervention services; faith-based programs; and education and training about domestic violence. The report offers

recommendations for policymakers to address domestic violence through increased funding, substance abuse and mental health services, and policies to improve social opportunities and reduce intergenerational violence. The need for additional research on best practice interventions focused on healing; culturally competent domestic violence prevention and intervention models; differential treatment of African Americans in law enforcement, judicial, and child welfare systems; and the intersections of racism, oppression, discrimination, substance abuse, and domestic violence is discussed.

Ward Griffin, L., Chappell, M., & Williams, O. J. (2006). *Community insights on domestic violence among African Americans: Conversations about domestic violence and other issues affecting their community.* St. Paul, MN: IDVAAC.

This report on perceptions of domestic violence among African Americans living in eastern North Carolina aims to 1) increase understanding of the causes and consequences of domestic violence and 2) inform service providers, criminal justice practitioners, public officials, and other stakeholders about how domestic violence manifests uniquely in African American communities. To add to the evolving literature on domestic violence among African Americans, community assessment sessions were conducted with the following community stakeholders: child and youth workers; members of the faith community; community activists; human services representatives; members of the LGBT community; and law enforcement representatives. Participants in the community assessment sessions suggested that: violence is pervasive in all communities and domestic violence is connected to other forms of violence; because African Americans' definition of domestic violence differs from White communities' conceptualization, proposed methods to end violence must be tailored to African Americans; violence among African American youth is motivated by a desire for social and economic respect; desegregation has negatively affected community and family cohesion; lack of funding and rural settings are challenges to addressing domestic violence in eastern North Carolina; and community awareness campaigns, breaking the "code of silence," and comprehensive, culturally based interventions are needed to address domestic violence in the local African American community. The report informs practitioners on the need for more culturally-based prevention and intervention services, particularly for rural communities; education and interdisciplinary training on domestic violence; and faith-based programs. The report offers recommendations for policymakers to address domestic violence through increased funding, substance abuse and mental health services, and policies. Additional research on best practice interventions for rural communities and culturally competent domestic violence prevention and intervention models; differential treatment of African Americans in law enforcement, judicial, and child welfare systems; and the intersections of racism, oppression, discrimination, substance abuse, and domestic violence and is recommended.

Hampton, R. L., Carrillo, R., & Kim, J. (2005). Domestic violence in African American communities. In N. J. Sokoloff & C. Pratt (eds.), *Domestic violence at the margins: Readings on race, class, gender, and culture* (pp. 127-141). New Brunswick, NJ: Rutgers University Press.

This chapter reviews the literature on the prevalence of domestic violence in African American communities and puts disproportionately high rates of violence in context. The authors discuss the socioeconomic factors and structural inequalities that underlie racial differences in rates of

domestic violence. These factors include poverty; unemployment; racial, ethnic, and social isolation; family disruption; and social disorganization. When controlling for factors such as socioeconomic status, studies have found that racial differences in the rates of abuse no longer were significant. Given the significance of social and contextual factors related to domestic violence, the authors recommend future research that thoroughly examines variables such as racial and economic segregation and inequalities, residential mobility, neighborhood structure, social organization and disorganization, and the complexities of socioeconomic factors.

Hampton, R., Oliver, W., & Magarian, L. (2003). Domestic violence in the African American community: An analysis of social and structural factors. *Violence Against Women, 9,* 533-557.

This article frames intimate partner violence (IPV) as a public health issue, particularly for African American women. Domestic violence uniquely impacts African American women, as the intersection of IPV and institutional racism compounds cycles of violence. The article discusses how effects of racism and structural barriers such as frustration and anger are displaced on intimate partners and contribute to the prevalence of IPV in the African American community. Recommended interventions that consider the interconnection of social, cultural, and situational are presented. Suggested interventions included school retention programs, job readiness and placement programs, and low-interest educational loans to the reduce underemployment and unemployment that is a major cause of stress among African Americans; community-based efforts to change boys' and men's attitudes about manhood and womanhood and to address sexism; and community conversations and retreats designed to strengthen male-female relationships.

Oliver, W., & Williams, O. J. (2005). *Community insights on domestic violence among African Americans: Conversations about domestic violence and other issues affecting their community.* St. Paul, MN: IDVAAC.

This report on perceptions of domestic violence among African Americans living in Minneapolis, MN aims to 1) increase understanding of the causes and consequences of domestic violence and 2) inform service providers, criminal justice practitioners, public officials, and other stakeholders about how domestic violence manifests uniquely in African American communities. To add to the evolving literature on domestic violence among African Americans, group discussions were conducted with the following community stakeholders: child and youth workers; human services workers; community activists; members of the faith community; members of the LGBT community; and law enforcement representatives. Stakeholders suggested that: interpersonal violence is common among African Americans in Minneapolis; abuse of women is tolerated in the African American community; structural barriers and social problems contribute to interpersonal violence in the African American community; African Americans' social isolation and minority status in Minneapolis negatively affect their capacity to address social stressors that contribute to violence and are barriers to support to African American women who experience intimate partner violence (IPV); community breakdown is another barrier to effectively responding to domestic violence; public awareness campaigns and collaborations between public and community-based agencies are needed to address domestic violence; and African American men who perpetrate IPV must be held accountable.

West, C. M. (2005). Domestic violence in ethnically and racially diverse families. In N. J. Sokoloff & C. Pratt (eds.), *Domestic violence at the margins: Readings on race, class, gender, and culture* (pp. 157-173). New Brunswick, NJ: Rutgers University Press.

This chapter discusses the social structural context that is necessary to consider in order to understand domestic violence in families of color. The chapter describes the major racial and ethnic groups in the United States (i.e., African American, Asian American, Native American, and Hispanic/Latino); discusses factors that contribute to ethnic differences including demographic (e.g., employment status) and cultural (e.g., level of acculturation) factors; discusses the intersectionality of oppressions that increase the risk of violence in families of color; and describes strengths and adaptive beliefs and practices (e.g., spirituality, prayer) that are protective against negative impacts of violence. A particular phenomenon explored is the "political gag order," or community pressure to suppress information about domestic violence to protect oneself or community from stereotypes, stigma, social policies, and expected negative treatment in various systems. The author concludes that this community pressure and discouragement have decreased and survivors are more willing to reveal abuse. To advance the field and support for families who have experienced domestic violence, further examination of the intersection of social class, geography, race, ethnicity, and domestic violence; ethnic differences in dating relationships; and systems of oppression by researchers in collaboration with community members, activists, and survivors was recommended.

Williams, O. J., & Tubbs, C. Y. (2002). *Community insights on domestic violence among African Americans: Conversations about domestic violence and other issues affecting their community.* St. Paul, MN: IDVAAC.

This report on perceptions of domestic violence among African Americans living in the San Francisco and Oakland, CA area aims to increase understanding of the impact of domestic violence in the local community and address gaps in the literature pertaining to African Americans' perceptions of domestic violence. Extant literature focused on clinical outcomes, individual and family responses to violence, and health and criminal justice data often compare African Americans to other racial and ethnic groups without sufficiently appreciating the complexities of the communities, diversity among African Americans, and the interaction of factors related to violence. Community assessment interview sessions were conducted with African American community representatives to elucidate perceptions of the types, causes, and consequences of domestic violence; barriers to addressing violence; and solutions to domestic violence. The participants, comprising activists, members of the faith community, human service representatives, law enforcement representatives, and LGBT advocates, had expertise in the area of domestic violence and were committed to eradicating it in their local community. The assessment sessions revealed that: community members were concerned about the prevalence of violence in their communities more broadly (community, domestic, etc.); domestic violence was part of a continuum of violence linking families and communities; participants believed that the prevalence of domestic violence was in part due to the deficit of both leadership and positive models for nonviolence; racism and social oppression were connected to violence in the African American community; community deterioration and negative intergenerational impacts were expected outcomes of violence and domestic violence; competiveness and inadequate resources were barriers to effectively responding to domestic

violence; and systemic and holistic solutions to domestic violence are recommended to best support the African American community. The findings are useful for continued conversations on how the African American community can effect change to reduce violence and promote health, well-being, and safety. The report also provides practitioners with insights into intervention planning, service gaps, and anti-violence messaging as well as encourages policymakers' and researchers' participation in working with African American community members to develop solutions to domestic violence.

2.2 Racial and Ethnic Bias and Disparities

Johnson, R. L., Saha, S., Arbelaez, J. J., Beach, M. C., & Cooper, L. A. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine, 19,* 101-110. Retrieved from http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1492144&blobtype=pdf

This article summarizes the 2001 Commonwealth Fund Health Care Quality Telephone Survey of racial and ethnic differences in patients' perceptions of primary care providers. African Americans, Hispanics/Latinos, and Asian Americans were more likely than Whites to believe that they would have received better medical care if they were of a different race or ethnicity and to feel treated unfairly or disrespected by medical staff based on race, ethnicity, or English-speaking ability.

Jones, C. P. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health, 90,* 1212-1215. Retrieved from http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.90.8.1212

This article outlines a theoretical framework for understanding racism on three levels: 1) institutionalized, 2) personally mediated, and 3) internalized. Institutionalized racism involves differential access to goods, services, and societal opportunities according to race. Personally mediated racism is prejudice, discrimination, and differential assumptions about and actions toward others based on race. Internalized racism involves racially stigmatized individuals' acceptance of negative messages about their own abilities and intrinsic worth. The author uses an allegory, "The Gardener's Tale," to illustrate the relationships among the three levels of racism. This frequently cited article has been used to encourage thinking and conversation about race, health disparities, and health equity.

Smedley, B. D., Stith, A. Y., & Nelson, A. R., eds. (2003). *Unequal treatment: Confronting racial and ethnic disparities in healthcare. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.* Institute of Medicine. Washington, DC: National Academy Press. Retrieved from http://www.nap.edu/books/030908265X/html

This report assesses racial and ethnic disparities in health care; 2) evaluates potential individual, institutional, and systemic contributors to disparities; and 3) offers recommendations to eliminate disparities. Over 100 peer-reviewed articles published between 1993 and 2003 on socioeconomic and geographic differences in health care services were reviewed. These studies found that health disparities exist in health systems and providers as well as in the context of social and economic inequalities. Further research is needed to more thoroughly understand the relationship among these factors and health outcomes.

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health, 93,* 200-209. Retrieved from http://www.ajph.org/cgi/reprint/93/2/200?ck=nck

This article summarizes research on the association between racial and ethnic discrimination and health. Over 50 studies completed between 1998 and 2003 on mental health, physical health, and health behaviors were reviewed. The studies found that perceived discrimination and bias were race-related stressors that negatively affected health. Despite limitations around measures of exposure to discrimination and determining how discrimination and bias contribute to health risk and disparities, the findings suggested a relationship between perceived discrimination and poorer health among racial and ethnic minority and socially disadvantaged groups.

3. Culturally Specific Populations, Services, and Programs

Despite some previous considerations as positive, cultural blindness is not an effective approach to serve culturally diverse populations and precedes cultural pre-competence, competence, proficiency, and responsiveness on cultural competence continua.[4,5,6] "One-size-fits-all" approaches and services do not adequately consider the experiences, values, and preferences of people of African descent or allow for tailored, culturally responsive services.[7,8,9] Research has examined promising practices for serving culturally specific populations in general and individuals who experience domestic and gender-based violence in particular. This research can inform the development of community-based domestic violence services, curricula, and supports that are welcoming and relevant to diverse populations.

3.1 Culturally Specific Populations

Napoles-Springer, A. M., Santoyo, J., Houston, K., Perez-Stable, E. J., & Stewart, A. L. (2005). Patients' perceptions of cultural factors affecting the quality of their medical encounters. *Health Expectations, 8,* 4-17. Retrieved from http://repositories.cdlib.org/cgi/viewcontent.cgi?article=2408&context=postprints

Introduction
This study examined cultural competency from patients' perspectives. The study aimed to identify key domains of cultural competency.

[4] Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a Culturally Competent System of Care, Volume I.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
[5] Goode, T. (2004). *Cultural competence- continuum.* National Center for Cultural Competence. Georgetown University Center for Child and Human Development, University Center for Excellence in Developmental Disabilities. Retrieved from http://nccc.georgetown.edu/projects/sids/dvd/continuum.pdf
[6] Williams, O. J. (2007). *Supervised Visitation: Concepts in Creating Culturally Responsive Services for Supervised Visitation Centers.* St. Paul, MN: IDVAAC. Retrieved from http://idvaac.org/media/pubs/SuperVisitBook.pdf
[7] Bell, C. C., & Mattis, J. (2000). The importance of cultural competence in ministering to African American victims of domestic violence. *Violence Against Women, 6*, 515-532.
[8] Gillum, T. L. (2008). The benefits of a culturally specific intimate partner violence intervention for African American survivors. *Violence Against Women,14,* 917-943.
[9] Williams, O. J., & Lance Becker, R. (1994). Domestic partner abuse treatment programs and cultural competence: The results of a national survey. *Violence and Victims, 9*, 287-296.

Methodology
Nineteen focus groups were conducted with a sample of African American (38%), Latino (28%), and White (34%) participants from the San Francisco area. Discussion topics included the meaning of culture and cultural factors that influence the quality of medical encounters.

Results
All racial/ethnic groups' definitions of culture included the concepts of value systems, customs, self-identified ethnicity, nationality, and stereotypes. For all racial/ethnic groups, providers' sensitivity to complementary and alternative medicine; health insurance-, social class-, and age-based discrimination; and racial/ethnic concordance between physician and patient influenced the quality of their medical encounters. Ethnicity-based discrimination as well as physicians' sensitivity to patients' spirituality and preferences to involve family members in care decisions influenced the quality of medical encounters of African American and Latino participants. African American participants also noted that physicians' insensitivity to patients' subjective experiences and perceived causes of illness affected their medical encounters.

Conclusions and Implications
Providers' cultural flexibility and responsiveness are necessary for the delivery of quality health care to racially, ethnically, and culturally diverse populations. Interventions should address culturally-specific factors that may affect health-related experiences and perceptions. Specific recommendations to enhance quality of care to diverse populations included using a humanistic approach, being sensitive to patients' privacy and preferences, and treating patients as equal partners in their health care.

Wilson-Stronks, A., Lee, K. K., Cordero, C. L., Kopp, A. L., & Galvez, E. (2008). ***One size does not fit all: Meeting the health care needs of diverse populations.*** **Oakbrook Terrace, IL: The Joint Commission. Retrieved from http://www.jointcommission.org/assets/1/6/hlconesizefinal.pdf**

Introduction
The report aimed to help organizations meet the needs of increasingly diverse populations and address challenges to providing safe, quality health care in increasingly complex systems. The report underscores that a "one size fits all" solution for cultural competence does not exist but that organizations can apply a framework of promising practices to serve diverse populations.

Methodology
Cultural and language promising practices were identified through site visits conducted at 60 hospitals. Site visits consisted of semi-structured interviews with hospital leadership, human resources staff, and cultural and language services staff. Noted practices were reviewed to identify common themes.

Results
A review of hospital practices yielded a framework of four themes for systemically providing culturally and linguistically appropriate care: 1) building a foundation, 2) accommodating the needs of specific populations, 3) collecting and using data to improve services, and 4) establishing internal and external collaborations. Building a foundation involves establishing policies, procedures, organizational leadership, and an organizational commitment that

support cultural competence. Accommodating the needs of specific populations involves reducing health disparities and providing safe, quality care while considering convenience and cost. Collecting and using community- and patient-level data helps organizations measure, monitor, and evaluate the quality, effectiveness, and utilization of cultural and language services. Collaborative practices involve building partnerships among departments, organizations, providers, individuals, and champions of culturally and linguistically appropriate care.

Conclusions and Implications

Promising cultural and language practices to serve culturally diverse populations should be adopted in a systematic manner rather than applied individually. Regular assessment of the recommended practices is needed to evaluate effectiveness, promote discussion, and guide service development and improvement to address the needs of populations served.

Working Group on Cultural Competence in Managed Mental Health Care. (1998). *Cultural competence standards in managed mental health care for four underserved/underrepresented racial/ethnic groups.* Rockville, MD: Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

This reports presents the work of four national panels to develop cultural competency standards in mental health services for four racial or ethnic groups: African Americans, Latinos, Native American/Alaskan Natives and Asian/Pacific Islander Americans. Each panel reviewed literature on mental health research and services for a particular racial or ethnic group and developed a set of 16 guiding principles for providing racially- and ethnically-specific mental health care, standards for eight aspects of health care systems, and standards for nine aspects of clinical care. Standards for providers included knowledge, understanding, and skills related to: patients' backgrounds; health issues among different racial and ethnic groups; providing appropriate, quality treatment; effective cross-cultural communication; treating patients respectfully; providing quality assessments; and creating and implementing quality care and treatment plans.

Domestic Violence- and Sexual Assault-Related Studies

Abugideiri, S. E. (2010). *A perspective on domestic violence in the Muslim community.* FaithTrust Institute. Retrieved from
http://www.faithtrustinstitute.org/resources/articles/DV-in-Muslim-Community.pdf

This article discusses the diversity of the Muslim community in the U.S., which can present challenges and opportunities in addressing domestic violence. The largest subgroups of Muslims in the U.S. are South Asian, Arab, and African American. Because Muslims often are part of studies of ethnic groups that do not examine their identity as Muslims and due to reluctance to report domestic violence, little data exist about the incidence of domestic violence among Muslims. The author, however, describes recent progress in acknowledging and addressing domestic violence among Muslims and discusses areas for consideration. A critical area is cultural and religious practices and experiences that may contribute to domestic

violence or serve as protective factors. Gender roles, acculturation, value of the institution of marriage, and Islamic teachings on interpersonal relationships, for instance, must be understood by those within and outside of the Muslim community. Continued development of culturally sensitive responses to domestic violence are needed to support diverse Muslim communities. Recommended efforts to expand include training Muslim leaders and educating the community about domestic violence, mobilizing resources, and taking public stands against domestic violence.

Abugideiri, S. (2011). Domestic violence: Muslim communities: United States of America. In S. Joseph (ed.), *Encyclopedia of Women & Islamic Cultures.* Retrieved from http://www.peacefulfamilies.org/Dv%20Muslim%20Communities%20EWIC%202011.pdf

Despite progress in the availability of services and treatment for survivors and perpetrators of domestic violence, the Muslim American community remains underserved. Additionally, relatively little research about the prevalence of domestic violence among Muslims exists. This article describes the Muslim population in the U.S., which is estimated at five to eight million people.[10] The majority of Muslims in America are immigrants, and the majority of U.S.-born Muslims are African Americans. The diversity of the Muslim population is critical to consider for effective domestic violence prevention and intervention efforts. The author discusses cultural and religious identity; cultural beliefs that can either support or discourage abuse; interpretations of Islamic teachings; culture-specific manifestations of abuse; diverse historical contexts (e.g., racism African American Muslims have experienced); and religious abuse, or the use of religious values and teachings to manipulate and control. Muslim Americans who seek domestic violence services have relied on the mainstream services available. To increase culturally specific and appropriate domestic violence services, understanding of the diverse responses Muslim Americans may have to domestic violence is important; interventions that draw upon cultural and religious strengths; collaboration with natural supports; trainings about domestic violence; and research on prevalence rates, risk and protective factors, and best practices for prevention and intervention are needed.

Hampton, R. L., & Oliver, W. (2006). Violence in the Black family: What we know, where do we go? In *Interpersonal Violence in the African-American Community* (pp. 1-15). Springer US.

This chapter discusses the evolution of research on domestic violence and culture. Decades ago, race neutral approaches were prevalent in research and practice. As the literature on domestic violence has increased, research incorporating culture has emerged. Gaps persist, however, in research, theory, and practice for communities of color. A particularly scant area is the intersection of intimate partner violence (IPV) and prisoner reentry. Although research has found that incarcerated and paroled men may experience conflict with their partners during and after incarceration, less is known about the context and dynamics associated with IPV upon reentry to the community. Further study of the relationship between race, ethnicity, culture, and violence among African Americans in various contexts and in other communities is needed to effectively address interpersonal violence in the African American community.

[10] As cited in Esposito, J. L. (2010). *The future of Islam.* New York, NY: Oxford University Press.

Hampton, R., Thomas, J., Bent-Goodley, T., & Gillum, T. (2015). ***"Facts about domestic violence and African American women": Institute on Domestic Violence in The African American Community.*** **St. Paul, MN: University of Minnesota, School of Social Work.**

This fact sheet includes six articles that explore domestic violence specifically focusing on African American women. Robert Hampton's article on Black female homicide provides sobering statistics of domestic violence. He provides facts and explores the reasons why Black women remain in abusive relationships, and provides recommendations to prevent homicide of Black women. Hampton also discusses health disparities among Black female survivors of domestic violence, exploring mental and physical health disparities among Black women compared to their White counterparts and offering recommendations, specifically by looking at the "Full Frame Initiative." Joyce Thomas explores the intersection of domestic violence and child maltreatment, concluding that children exposed to domestic violence are more likely to suffer physical, emotional, behavioral, and mental problems than children who are not exposed to violence. Thomas recommends parental education, home visitation programs, and strategies to promote the social and emotional well-being of children. Tricia Bent-Goodley discusses the intersection between domestic violence and HIV/AIDS, explaining that women in abusive relationships may be forced to engage in sexual acts with a partner and others and may be limited in their ability to negotiate the use of safe sex practices due to the threat of violence. Bent-Goodley notes that not acknowledging this intersection can increase the risk of HIV/AIDS among domestic violence victims and encourages dialogue and a healthy relationship educational framework. Tameka Gillum discusses the intersection of domestic violence and trauma to African American women. She provides statistics and facts as well as contrasts the statistics of African American and White women, highlighting the higher trend of trauma in African American women. Gillum recommends culturally specific curricula, community support and engagement, and intimate partner violence programs that incorporate spirituality and faith-based organizations.

Pierce-Baker, C. (1998). ***Surviving the silence: Black women's stories of rape.*** **New York, NY: W. W. Norton & Company.**

This book tells the accounts of Black women who have been raped and who have felt that they had to remain silent to protect themselves and the perpetrators. The author shares her own account of rape and describes her family's response. In addition to the experiences of the survivors interviewed, the book includes the voices of Black men who have supported rape survivors. The aim of sharing the stories of women who survived trauma is to engender healing, a sense of community, empowerment, freedom, and self-love.

Richie, B. E. (1996). ***Compelled to crime: The gender entrapment of battered black women.*** **New York, NY: Routledge.**

This book tells the stories of African American women, primarily from low-income communities, who are incarcerated and have survived physical, sexual, and emotional abuse. The collection of stories is based on life-history interviews with women in a New York correctional facility and illustrates how threatening circumstances lead to feelings of

constraint, lack of control, and desperation; tense intimate relationships; unmet needs; deferred dreams; and difficult choices. The impact of stigma, isolation, marginalization, and social constructs on women's experiences and the intersection of gender, race/ethnicity, and violence are explored. The author borrows from the legal concept of gender entrapment to examine circumstances that lure individuals into compromising acts and how vulnerability to men's violence in intimate relationships, racialized gender identities, societal mores, and culturally expected appropriate gender roles may contribute to behavior for which the women are penalized. Involvement in the legal system decreases their access to needed counseling and services to help them deal with complex issues and experiences. The book challenges popular beliefs that women's psychological, moral, or social "inadequacies" cause their experiences with violence, poverty, and crime. The themes around how the development of a female identity in African American families influences women's adult intimate relationships and how exposure to violence influenced their involvement in crime shed light on a population whose lives and experiences are often misunderstood.

West, C. M. (2002). Battered, black, and blue: An overview of violence in the lives of Black women. *Women & Therapy*, *25*(3-4), 5-27.

This article examines the various forms of violence that affect African American women, including childhood sexual abuse, dating and intimate partner violence (IPV), sexual assault, and sexual harassment. The author defines each form of violence and discusses prevalence rates, risk factors, and resiliency. Mental and physical health consequences of violence are explored, including depression, anxiety, substance abuse, suicidality, sexually transmitted diseases, and reproductive health problems. To foster healing, the author recommends the use of culturally sensitive interventions and medical care; research processes to empower Black women; addressing gaps in research on relationships and IPV, including violence in lesbian relationships; expanding research to better reflect diversity among African American women; further engaging the Black church in violence prevention and intervention; and encouraging health professionals and scholars to become activists of social change.

West, C. M. (2004). Black women and intimate partner violence. *Journal of Interpersonal Violence, 19,* 1487-1493.

This article reviews sociodemographic factors that make African American women particularly vulnerable to intimate partner violence (IPV). Research suggests that social and economic disadvantage, marginalization, and structural racism place African American women at risk for IPV. Specific risk factors include young age, low income, low educational attainment, and unemployment. The author recommended more culturally sensitive research to thoroughly understand violence in Black communities. Future research directions suggested include examination of the diversity among Black Americans; intersectionality of oppressions (e.g., sexism, racism, discrimination, classism, homophobia); complex, multigenerational trauma; oppressive images that include views of African American women as sexualized and promiscuous; protective factors and resiliency (e.g., spirituality, activism, literature, and music to promote healing); and careful exploration of racial similarities and differences. The author emphasized the importance of researchers, therapists, activists, community members, and survivors working collaboratively to develop culturally sensitive theories and models to understand the complexity of violence in ethnically diverse families.

Wyatt, G. E. (1997). *Stolen women: Reclaiming our sexuality, taking back our lives.* New York, NY: John Wiley and Sons, Inc.

This book explores African American female sexuality, defining the concept and discussing how

sexuality shapes the lives of African American women. The book aims to add to the paucity of objective frameworks and studies in this area. The author examines sexuality inter-generationally through an in-depth analysis based on clinical research and interviews with hundreds of women from ages 18 to 80 years who represent diverse racial, ethnic, cultural, and socioeconomic backgrounds. The focus is on ethnic and cultural factors rather than on racial differences in sexual experiences. Part I, "Redefining Our Image" traces the history of Black sexuality through five centuries and examines how stereotypes continue to threaten sexuality. Part II, "Understanding Our Sexuality" explores formative sexual experiences, effects of those experiences across the lifespan, cultural patterns of behavior, and principles and knowledge that enable Black women to take responsibility for themselves and their sexuality. These experiences include puberty, adolescent and adult intimate relationships, and sexual abuse. Part III, "Taking Back Our Lives" encourages self-awareness, and includes a sexual responsibility test for readers to identify personal problems, challenges, and potential. The book's in-depth exploration of the sexuality of African American females responds to the historical devaluing and depersonalization of women of color and sexualization of African American women in particular.

3.2 Culturally Specific Services and Programs

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent health care systems: A systematic review. *American Journal of Preventive Medicine, 24,* 68-79.

This article reviewed five interventions to improve cultural competency in health care systems and service delivery to diverse populations: 1) recruitment of a culturally diverse workforce, 2) establishment of culturally specific health care settings where providers reflect the populations served, 3) development of appropriate education materials, 4) availability of trained interpreters or bilingual staff, and 5) cultural competency training. The effect of these interventions on client satisfaction and treatment, racial and ethnic differences in health care utilization, and health outcomes could not be determined from extant studies. The authors recommended further research on cultural competence strategies, provider knowledge attitudes, and associated patient outcomes.

Mahoney, D. (2005). Prevention in action: Cultural sensitivity is essential. *Clinical Psychiatry News, 33.*

This article emphasizes the need for culturally specific interventions to address problems that are specific to a particular community. The author reviewed a case of a Native American teenager who killed nine people in a school shooting and himself, and concluded that he "fell through the cracks." The author also concluded that there are issues and needs within the Native American culture that are specific to that culture and, therefore, culturally sensitive and specific interventions that can provide Native American youth with a safety net are needed.

Resnicow, K., Baranowski, T., Ahluwalia, J. S., & Braithwaite, R. L. (1999). Cultural sensitivity in public health: Defined and demystified. *Ethnicity and Disease, 9,* 10-21.

This article describes a health communication research-based framework for developing culturally sensitive public health programs. In the framework, cultural sensitivity comprises two dimensions: 1) surface structure and 2) deep structure. Surface structure refers to matching intervention materials and messages to the target group's observable characteristics (e.g., language, clothing, music, food) and to appropriate messaging media and mechanisms (e.g., community organizations and social support networks populations utilize). Deep structure refers to understanding the core cultural values and social, historical, environmental and psychological factors that influence individuals' health behavior. The authors discussed potential conflicts between public health goals and cultural values and the need for additional research on the efficacy of cultural competency interventions.

Siegel, B., Berliner, H., Adams, A., & Wasongarz, D. (2003). *Addressing health disparities in community settings: An analysis for best practices in community-based approaches to ending disparities in health care.* Princeton, NJ: Robert Wood Johnson Foundation.

This report describes and analyzes a number of best practices in community-based disparity initiatives, including: ensuring a continuum of resources and services for clients; engaging in one-on-one outreach that facilitates health education and health system navigation; and employing multiple strategies for cultural competency. The authors suggest the need for further development of community-based services that consider issues such as poverty, racism and lack of health insurance which affect access to services and for evaluation of the impact of culturally specific and relevant services on the health of minority populations.

Domestic Violence- and Sexual Assault-Related Services

Bent-Goodley, T. B. (2009). A black experience-based approach to gender-based violence. *Social Work, 54,* 262-269.

As women of color face increased barriers to treatment, particularly services that are culturally responsive, this article suggests the use of the Black Experience-Based Social Work (BEBSW) approach to adequately meet specific needs of African Americans. The BEBSW addresses the complexity of domestic violence through a culturally based approach that considers the social and cultural contexts in which African American women live. BEBSW draws from the field of social work, emphasizing Black experiences, values, perspectives, and methods of problem solving that are informed by the strategies and tools of Africans as well as African Americans during slavery and in rural areas after emancipation. The major concepts and stages of the BEBSW approach – moaning (a linear progression from suffering), mourning (collective healing and support), and morning (an ideal state of health, happiness, and transformation) – help address the needs of African American families that are affected by domestic violence.

Davis, S. P., Arnette, N. C., Bethea, K. S., Graves, K. N., Rhodes, M. N., Harp, S. E., ... & Kaslow, N. J. (2009). The Grady Nia Project: A culturally competent intervention for low-income, abused, and suicidal African American women. *Professional Psychology: Research and Practice, 40*, 141.

Intimate partner violence (IPV) within the African American community has led to high rates of attempted suicide. The trauma inflicted on victims of IPV as well as the lack of effective and culturally appropriate care increases rates of attempted suicide. The authors propose that culturally informed interventions such as the Grady Nia Project are needed to adequately provide treatment for African American women who have been abused and have suicidal ideations. The Grady Nia Project comprised 10 sessions of 90 minutes each in which survivors participated in A) weekly check-in and IPV and suicide assessment; B) interactive discussion of the week's topic; and C) group activities. A satisfaction survey showed that women who participated in this project were incredibly pleased with the services they received and that participation in the project reduced their suicidality. The Grady Nia Project was considered unique in that it recognizes protective factors among African American women that reduce their risk of suicide and incorporates an understanding that the women's responses to IPV reflect their social context and experiences with racism.

Gillum, T. L. (2009). Improving services to African American survivors of IPV from the voices of recipients of culturally specific services. *Violence Against Women*, *15*, 57-80.

Introduction
The article addresses the dearth of literature and attention focused on intimate partner violence (IPV) in African American communities. The study aimed to explore culturally appropriate interventions, which are designed specifically for a target population and are consistent with the cultural framework of the population served.

Methodology
The study utilized qualitative methods to culturally specific services for IPV. A sample of 14 African American women who had experienced domestic violence completed in-depth semi-structured interviews to assess their impressions of culturally specific versus mainstream services.

Results
Participants responded more favorably to culturally specific services than to mainstream services. Though there were some positive aspects of mainstream services such as basic feelings of comfort and support as well as some available assistance, the women's experiences were mostly negative. The negative components of mainstream services cited included perceptions of organizational environments that were non-supportive and not welcoming to African Americans; insensitivity to the process of leaving an abusive relationship; barriers to adequate assistance; and help that only partially met needs. Interviewees cited a welcoming and supportive environment; structures that increase available assistance; and greater sensitivity to the process of leaving an abusive relationship as salient characteristics of culturally specific services.

Conclusions and Implications

The findings suggest that use of a color-blind approach when addressing IPV may not be sufficiently inclusive and supportive for African American women. Rather, culturally specific and tailored interventions that take into account the culture-specific values, norms, attitudes, expectations, and customs of the populations served may be more comfortable and effective. Promising practices include utilizing language and settings familiar to the population of interest; staff who share the culture of the population served; and material designed in collaboration with members of the target population.

Popescu, M., Drumm, R., Mayer, S., Cooper, L., Foster, T., Seifert, M., ... & Dewan, S. (2009). "Because of my beliefs that I had acquired from the church...": Religious belief-based barriers for Adventist women in domestic violence relationships. *Social Work and Christianity, 36,* 394.

Introduction

The purpose of this study is to understand the lived experiences of female survivors of domestic violence. The study examined religious belief-based barriers that Seventh-day Adventist women encounter as they move from domestic violence toward safety in their relationships.

Methods

The study explored an internal layer of religious beliefs, external social reinforcers of beliefs, and belief barriers using the Transtheoretical Model of Behavior Change (Prochaska & DiClemente, 1984).

Results

The study found that Seventh-day Adventist women encountered a number of religious belief-based barriers as they moved from being in their abusive relationships to experiencing safety. Three categories of internal religious belief-based barriers emerged: beliefs about marriage and divorce; stereotypes about Christians; and beliefs about Christian gender roles. Nearly all of the women in the sample (93%) held at least one of these belief barriers. As women shared beliefs that contributed to their staying in abusive relationships, they also revealed how other people in their lives such as clergy, church members, family members, and partners externally reinforced these beliefs.

Conclusions and Implications

The study contributed to the current literature by presenting beliefs that may affect women in conservative faith communities and introducing a conceptual approach to change for women survivors of intimate partner violence in conservative faith communities. The findings can inform the practice of social workers and clergy.

West, C., & Johnson, K. (2013, March). *Sexual violence in the lives of African American women.* Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence. Retrieved from http://www.vawnet.org

With the unique sociohistorical context of domestic and sexual violence in African American communities, this article aimed to provide a historical overview of sexual violence,

characteristics of African American survivors of rape, risk factors and health consequences of rape, and recommendations for culturally sensitive strategies to support African American survivors. In national studies, approximately 1 in 5 Black women had been raped in their lifetime, usually by someone known to them. Black girls and women who were of low-income, HIV-positive, bisexual, incarcerated, or engaged in risk-taking behaviors were at elevated risk. Survivors reported both immediate and long-term physical, sexual, and mental health effects of violence. The authors recommended that all professionals should learn more about African American history, sexual assault, and historical trauma. Providers should address barriers to disclosure that African American survivors may face (e.g., rape myth acceptance, concerns about stereotypes, and cultural mandates). Providers also should ask how survivors self-identify racially, ethnically, and culturally. Mental health professionals can conduct comprehensive interviews to document sexual violence and understand survivors' environment (e.g., home, school, work, community) to create a recovery path best suited to survivors' individual needs. Legal professionals should be trained to recognize and investigate sexual crimes and exploitation that involve marginalized Black women. Medical professionals should screen for sexual and physical victimization and document genital injuries. In all interactions, providers should be sensitive not to perpetuate victim-blaming attitudes. The authors also recommended that service providers use a strengths-based approach to bolster survivors' resilience and healing. Such approaches include educating community members about sexual assault; encouraging survivors to use their faith-based, community-based, and other social support networks; encouraging participation in activism; and promoting holistic healing practices (e.g., storytelling, journaling, and artistic expression).

Williams, O. J. (2011). ***Speaking of faith: Domestic violence programs and the African American church.*** **St. Paul, MN: Institute on Domestic Violence in the African American Community (IDVAAC).**

This guide was developed as a tool for clergy and lay leaders to use for training and to educate churches on faith-based approaches to addressing domestic violence in the Christian African American community. Meetings with faith leaders informed the development of the guide. The guide offers recommendations for holding perpetrators accountable and developing church policies as well as offers five action plans for the church: 1) making violence against women a critical concern; 2) ensuring that Christian faith-based environments are safe for survivors to discuss their experiences and seek healing; 3) developing strategies to meet the needs of women and girls exposed to violence; 4) leveraging secular victim services, advocacy programs, and treatment to enhance community responses to violence against women; and 5) securing financial support for faith-based groups and organizations developing responses to violence against women and children.

The guide discusses strategies for implementing domestic violence prevention and intervention programs, and the accompanying DVD presents various churches' responses to domestic violence and supports for women who have been abused. Each section of the guide explores social justice, healing, safety, comprehensive responses, and theological and biblical approaches to address domestic violence. Contributing author, Minister La Donna Combs, examines basic concepts, definitions, and dynamics of domestic violence. She also addresses challenges the African American community faces around domestic violence. Dr. Sharon Ellis presents a Christian faith-based perspective for understanding domestic violence and its

impact on victims, perpetrators, and the larger community. She also discusses how the church is uniquely positioned to minister to survivors and perpetrators of domestic violence as well as help break the intersecting systems of oppression that impact African American women. Rev. J. R. Thicklin explains the epidemic of domestic violence and the insufficient response from the church and faith-based communities. Rev. Thicklin issues a call to action for the church to become "equipped, educated, and empowered" to address domestic violence. He proposes objectives for the church, which include: 1) raising awareness of the role of churches in addressing domestic violence; 2) proactively preventing domestic violence; 3) establishing clear guidelines and policies for addressing domestic violence; 4) understanding their role in coordinating a response to domestic violence; and 5) establishing clear objectives of "education, assistance, restoration, and transformation." The guide aims for churches to integrate prevention and healthy relationships into their missions.

4. Cultural Competency

Research suggests that cultural competency is related to quality, equitable health-related care and services. Cultural competency has evolved from a primarily individual focus to focus on multilevel factors including individual, organizational, system, and community. Multilevel culturally competent practices and procedures are necessary to ensure to effectively serve diverse populations.[11]

Alizadeh, S., & Chavan, M. (2015). Cultural competence dimensions and outcomes: a systematic review of the literature. *Health and Social Care in the Community.*

This systematic literature review aimed to explore dimensions and definitions of cultural competence within a health care setting. Several elements necessary for cultural competence were found, including cultural awareness, cultural knowledge, and cultural skills and behavior. The authors defined cultural competence as "the ability to work and communicate appropriately and effectively with people from culturally different backgrounds." Appropriateness implies not violating valued rules, and effectiveness refers to achieving goals and outcomes in intercultural interactions.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong 2nd, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*, 293.

This literature review explored the definition and evolution of understanding of cultural competence. Medical and public health academic, foundation, and government literature was reviewed to identify key components of cultural competence, sociocultural barriers to health care, and strategies to incorporate culturally competent interventions into service delivery. Cultural competence in health care entails understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact with the health care delivery system; and devising interventions that take these issues into account to assure quality health care delivery to diverse populations. The article noted a lack of consensus in previous literature that has tried to conceptualize cultural competency using

[11] Andrulis, D., Delbanco, R., Avakian, L., & Shaw-Taylor, Y. (2000). Conducting a cultural competency self-assessment.

terms such as cultural sensitivity, responsiveness, effectiveness, and humility. From the reviewed literature, the authors identified sociocultural barriers to health care at the organizational (leadership and workforce), structural (processes of care), and clinical (provider-patient encounters) levels. An emerging cultural competence framework to increase access to quality care included: greater recruitment and hiring of health professionals of color; developing interpreter services and culturally and linguistically appropriate health education materials; and educating providers on cross-cultural issues. To effectively address organizational, clinical, and structural social barriers and improve care, culturally competent interventions must include organizational, structural, and clinical components.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*, 499-505.

Introduction
The study examined components of cultural competence and leverage points for action and implementation to increase quality of health care for diverse populations.

Methodology
The study utilized qualitative methods to examine the importance of cultural competence in health care settings. A sample of 37 cultural competence experts from managed care, government, and academia participated in key informant interviews.

Results
Participants provided a list of capacities of cultural competence, which included diversity among staff and providers; system capacities such as data collection and effective interpreter services; and education management, providers, and staff.

Conclusions and Implications
Cultural competence comprises individual, organizational, and systemic skills and resources. Ongoing development and implementation of these skills and resources can help increase the quality of services to diverse populations and ultimately reduce health disparities.

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic disparities? A review and conceptual model. *Medical Care Research and Review, 57,* 181-217.

This comprehensive literature review found a greater emphasis in the cultural competence field on the individual (e.g., provider, patient) than on the system in which individuals function. Direct associations between cultural competence and patient outcomes were not found. Drawing upon the literature, the authors presented a conceptual model of cultural competency techniques that may affect health processes and outcomes for communities of color. The most frequently cited techniques in the literature included culturally competent health promotion; accommodation of cultural differences; provider and staff recruitment, hiring, and retention (e.g., of community health workers); training; interpreter services; coordinating with traditional healers; including family members in care; and cultural immersion.

Goode, T. D. (2004). ***Promoting cultural and linguistic competency: Self-assessment checklist for personnel providing primary health care services.*** **Washington, DC: Georgetown University Center for Child and Human Development.**

This frequently utilized brief cultural competency self-assessment tool contains multiple variations for different settings and service populations (e.g., primary care, early childhood, families with special health needs). The assessment asks respondents to evaluate cultural competency in terms of their physical environment, materials and resources for service recipients, communication style, and values and attitudes.

Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). ***The evidence base for cultural and linguistic competency in health care.*** **New York: The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf?section=4039**

This report assessed the existing evidence base for the impact and benefits of cultural and linguistic competence in physical and mental health care, which is considered essential for improving access, utilization, and quality of care. The authors conducted a structured search of primary sources, selected reviews, technical reports, and conceptual papers from 1995 to 2006 to identify relationships between cultural competence and health outcomes, well-being, and costs and benefits to the system (i.e., business case). The majority of the literature explored and defined relevant concepts and issues as well as identified important research questions. The review revealed some movement toward pilot and controlled studies to test the impact of cultural and linguistic competence on quality and effectiveness of care; existing evidence provided information on intermediate outcomes of short-term interventions. Few studies addressed cultural and linguistic competence at the organizational or policy level. Most of the conceptual literature on cost-benefits of linguistic competence was related to the provision of language access services such as interpretation and translation. Gaps in existing research included lack of definition, measurement, and isolated effects of cultural and linguistic competence. There also was a paucity of research that examined organizational capacity (e.g., policies, structures, and practices); cost-benefits of cultural and linguistic competence to patients, families, and communities; and projected or estimated cost savings of providing culturally competent care by racial or ethnic group, health condition, and type of intervention. To address these gaps, future directions should include: development of validated and shared definitions and frameworks of cultural competence; refined population definitions to include cultural variables other than race, ethnicity, or language; evaluations of specific effects of cultural and linguistic competence; reliable data collection on race, ethnicity, and culture; involvement of diverse patients and communities in designing, implementing, and evaluating services and supports; longitudinal and large sample studies; and examination of the relationship among organizational policies, structures, and practices, quality and effectiveness of care, and health outcomes and well-being.

Kairys, J. A., Orzano, J., Gregory, P., Stroebel, C., DiCicco-Bloom, B., Roemheld-Hamm, B., ... & Crabtree, B. F. (2002). Assessing diversity and quality in primary care through the multimethod assessment process (MAP). ***Quality Management in Health Care, 10,*** **1-14.**

This article proposes a multi-method assessment process (MAP) to systematically understand diversity, cultural competence, and quality improvement in clinical practice. MAP data were gathered through direct observation, document review, family medical histories, interviews, and surveys. The authors recommended collecting data in the following domains: 1) cultural sensitivity; 2) policies and procedures; 3) communication; 4) values/attitudes; 5) facility characteristics; 6) training and staff development; 7) intervention and treatment model features; 8) family and community participation; and 9) monitoring, evaluation, and research.

Lavizzo-Mourey, R. J., & MacKenzie, E. (1996). Cultural competence--an essential hybrid for delivering high quality care in the 1990's and beyond. ***Transactions of the American Clinical and Climatological Association, 107,*** **226.**

This paper addressed the heightened need for culturally competent services as the demography of the United States becomes increasingly heterogeneous in culture and ethnicity. The authors recommended the use of culturally competent intervention and services to provide the best care for minority populations. The paper defined cultural competence within a health model and discussed three essential components of delivering high quality services to diverse populations: 1) health-related cultural factors and beliefs, 2) epidemiology in the populations of interest, and 3) population-specific treatment outcomes.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. ***Journal of Health Care for the Poor and Underserved, 9*****, 117-125.**

The article contrasts the differences between cultural competence and cultural humility as well as which definition best fits within a health care setting. Cultural competence in clinical practice was defined not as a discrete endpoint but as a commitment to and active engagement in an ongoing process that individuals enter into with patients, communities, colleagues, and themselves. Cultural humility was defined as a process that requires individuals to continually engage in self-reflection and self-critique as lifelong learners and that helps mitigate power imbalances in physician-patient communication by using patient-focused care. The authors caution against a false sense of security that health care providers might have after training in cultural competence leading to stereotypes and beliefs that they have a sufficient understanding of diverse populations and best practices. Cultural humility, therefore, was the preferred approach because it called for self-reflection and ongoing learning.

Wu, E., & Martinez, M. (October 2006). ***Taking cultural competency from theory to action.*** **The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/publications/fund-reports/2006/oct/taking-cultural-competency-from-theory-to-action**

To address the focus on defining cultural competency over taking cultural competency from

theory to action, this paper provides principles and recommendations for implementing cultural competency in the field. The report discusses six key principles to a successful cultural competency effort: 1) Community representation and feedback at all stages of implementation; 2) Cultural competency integration into all existing systems of a health care organization, particularly quality improvement efforts; 3) Manageable, measurable, and sustainable changes; 4) Making the business case for undertaking cultural competency initiatives for sustainability; 5) Leadership commitment; and 6) Ongoing staff training. The authors developed these principles based on their connections with communities of color, experience advocating for cultural and linguistic requirements, and analysis of existing best-practice standards. To move from theory to practice, the report recommends that organizations: seek leaders of community groups to solicit concerns and recommendations; make cultural competency a component of quality improvement, patient safety, customer service, patient-provider interaction, and disease management; evaluate and quantify the impact of their cultural competency efforts; explore the business case for implementing cultural competency initiatives; recruit a racially and ethnically diverse workforce and leadership that are committed to health equity; and dedicate time, resources, and policies to regular staff trainings.

5. Culturally Competent, Relevant, and Responsive Organizations and Services

Cultural competence, relevance, and responsiveness must be infused into every aspect of health-related organizations, systems, programs, and services to advance preventive care and interventions for diverse populations. Conceptual models for organizational cultural competency include approaches to development, implementation, and assessment of culturally appropriate procedures and practices. Organizational cultural competency also involves relationship building among community members, direct service providers, organizational structures and processes, and larger systems and communities to leverage resources and sustain efforts to provide effective care.[12]

5.1 Culturally Competent Organizations

American Hospital Association (2004). ***Strategies for leadership: Does your hospital reflect the community it serves? A diversity and cultural proficiency tool for leaders.*** **Washington, DC: American Hospital Association. Retrieved from http://www.consumerstar.org/pubs/AHAassessment.pdf**

This brief assessment was developed as a starting point in evaluating the diversity, cultural proficiency, and needed practices of health care organizations. The tool assesses factors related to patient care, workforce development, organizational leadership, and community. The document contains suggestions for using the tool to raise awareness in organizations and case studies of successful diversity and cultural proficiency programs to inform organizational strategies to serve diverse populations.

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[12] Research & Training Center for Children's Mental Health (2006). *Organizational cultural competence: A review of assessment protocols.* Tampa, FL: University of South Florida. Retrieved from http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/protocol/CultCompProtocol.pdf

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). ***Cultural competence in health care: Emerging frameworks and practical approaches.*** **New York: The Commonwealth Fund. Retrieved from http://www.cmwf.org/usr_doc/betancourt_culturalcompetence_576.pdf**

To provide a framework for practical approaches to increase cultural competence in health care systems, this report evaluated definitions and components of cultural competence, identified models of culturally competent care, and presented recommendations to implement culturally competent interventions to improve the quality of care. Cultural competence is defined as the "ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" and serves as a means to increase access to quality care and business strategy to attract new patients. Barriers to culturally competent care include lack of diversity in the health care workforce, poorly designed systems of care, and poor patient-provider communication. Informed by academic, government, managed care, and community health models, the report makes a number of recommendations to enhance cultural competence. To strengthen *organizational* cultural competence, diversity should be maximized through: minority health care leadership development, hiring and promoting racially and ethnically diverse health providers, and involving community representatives in health care organizations' planning and quality improvement efforts. To strengthen *systemic* cultural competence, initiatives should include: community assessments, mechanisms for community and patient feedback, systems for patient racial/ethnic and language preference data collection, access to interpreter services, quality measures for cultural competence and diverse patient populations, and culturally and linguistically appropriate health-related materials and interventions. To strengthen *clinical* cultural competence, health providers should: increase their awareness of the impact of social and cultural factors on health beliefs and behaviors; receive ongoing training and education; and empower patients to become active partners in health care.

The Lewin Group, Inc. (2002). ***Indicators of cultural competence in health care delivery organizations: An organizational cultural competence assessment profile.*** **Washington, DC: Health Resources and Services Administration, U.S. Department of Health and Human Services.**

This article describes an analytic, organizing, and assessment framework that can be used as a tool to examine, demonstrate, and document cultural competence in health organizations. The framework is based on a synthesis of over 100 published and unpublished literature sources. The assessment profile consists of: 1) the cultural competence domains of organizational values, governance, planning, monitoring and evaluation, communication, staff development, organizational infrastructure, and services and interventions; 2) focus areas within domains; and 3) structure, process, and outcome indicators related to the focus areas.

Siegel, C., Davis-Chambers, E., Haugland, G., Bank, R., Aponte, C., & McCombs, H. (2000). Performance measures of cultural competency in mental health organizations. ***Administration and Policy in Mental Health, 28,*** **91-106.**

This article describes a multilevel framework for assessing the cultural competency of mental health organizations and systems. A steering committee reviewed over 20 reports and papers on cultural competency. Based upon the review, the following domains were identified: 1)

needs assessment, 2) information exchange, 3) services, 4) human resources, 5) policies and procedures, and 6) outcomes. These domains, and their factors, indicators, and measures, help assess cultural competency within three organizational structures: administrative, provider network, and individual caregiver.

Siegel, C., Haugland, G., & Davis-Chambers, E. (2003). Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. *Administration and Policy in Mental Health, 31,* 141-170.

Introduction
This article describes the second phase of a two-phase investigation of performance measures to assess organizational cultural competency development. The study aimed to select and benchmark performance measures of cultural competency in behavioral health care as well as recommend measures that organizations could use to guide implementation of culturally competent practices and assess cultural competency development.

Methodology
The study utilized input from an Expert Panel representing the four major ethnic and racial groups in the U.S. and individuals with extensive experience in cultural competency in health care. Survey and key informant interview data were gathered from 21 sites the Expert Panel identified. Panelists rated measures of cultural competency, which also were reviewed against the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care to ensure that the measures assessed all standards.

Results
Twelve categories of performance measures were identified at individual, administrative, service, and organizational levels: 1) Organizational commitment to cultural competence; 2) Integration of cultural competence within organizations; 3) Activities related to organizational cultural competence; 4) Cultural competence advisory committee; 5) Knowledge of cultural needs of populations and areas of focus; 6) Knowledge of cultural needs of service users; 7) Linguistic capacity; 8) Services; 9) Cultural competence training and education; 10) Recruitment, hiring, and retention; 11) Outcomes; and 12) Consumer and family education.

Conclusions and Implications
The identified performance measures reflect gold standard benchmarks in culturally competent organizations and services. The authors recommend implementing evidence-based practices as part of infusing cultural competence in service delivery. Assessment scales comprising performance measures and their benchmarks are critical in monitoring fidelity and adherence to practices to effectively serve culturally diverse populations.

5.2 Culturally Competent, Relevant, Responsive Services and Programs

Betancourt, J. R., ed. (2006). *Improving quality and achieving equity: The role of cultural competence in reducing racial and ethnic disparities in health care.* New York, NY: The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/publications/fund-reports/2006/oct/improving-quality-and-achieving-equity--the-role-of-cultural-competence-in-reducing-racial-and-ethni

In addition to being based on the best scientific evidence, it is recognized that health care also

should be responsive to patients' needs, easy to navigate, safe, and accessible. This report reviews cultural competence components and related principles of high quality care as well as offers recommendations to link the quality-of-care and cultural competence movements. The report outlines the six Institute of Medicine principles of quality: 1) safety, 2) effectiveness, 3) patient-centeredness, 4) timeliness, 5) efficiency, and 6) equity. Recommended culturally competent quality improvement approaches include: tailoring methods of care to patients' needs; supporting patients in managing their own health; ensuring language access in service provision (e.g., low literacy written materials, multilingual signage, interpreters); increasing access to health navigators; developing culturally appropriate curricula; and providing cultural competence education to providers.

Hogg Foundation for Mental Health (2001). ***Cultural competency: A practical guide for mental health service providers.*** **Saldaña, D., ed. Austin, TX: Hogg Foundation for Mental Health.**

This guide offers concrete strategies to improve the cultural competency of mental health service provision. Recommended strategies include: building rapport, eliminating communication barriers, conducting culturally sensitive assessments, evaluating culturally-related syndromes, and ensuring confidentiality.

Metzger, N. Q., Telfair, J., & Sorkin, D. (2006). Cultural competency and quality of care: Obtaining the patient's perspective. ***Commonwealth Fund*, *39.***

Providing culturally competent care can help reduce racial and ethnic health disparities. Understanding service recipients' impressions of the care they receive is necessary to fully assess the quality and effectiveness of services. This report identifies five domains of culturally competent care from patients' perspectives that should be considered in service provision and research: 1) patient-provider communication; 2) respect for patient preferences and shared decision-making; 3) experiences leading to trust or distrust; 4) experiences of discrimination; and 5) linguistic competency. The authors recommend practice and research strategies in each domain to increase health equity for communities of color, low income, and other underserved populations. Regarding patient-provider communication, providers should collect quantitative and qualitative data on service recipients' race/ethnicity, socioeconomic status, language skills and preferences, and research should examine factors that influence interactions among providers and patients from racially/ethnically diverse backgrounds. Providers should work collaboratively with patients to select treatments that take into account patients' health-related values and preferences. Providers and researchers should assess factors that affect patients' trust in providers; perceived discrimination and bias; and the effects of patient-provider racial concordance on health care access, quality, and outcomes. Providers and researchers should consider language concordance between patients with limited English proficiency or low health literacy and their providers as well as access to trained bilingual staff and professional language services. Patients' perspectives on culturally and linguistically appropriate services are critical measures of quality that can help monitor, evaluate, and improve health services.

U.S. Department of Health and Human Services Office of Minority Health (2016). ***The National CLAS Standards.*** **Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53**

Culturally and linguistically appropriate services are respectful of and responsive to patients' health beliefs, practices, preferences, and needs. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) aim to improve health care quality and equity by establishing a framework for organizations to effectively serve diverse communities. The standards consist of the principle of providing quality care and services that are effective, equitable, understandable, respectful, and culturally responsive. The standards also outline 14 strategies related to: a) Governance, leadership, and workforce; b) Communication and language assistance; and c) Engagement, Continuous Improvement, and Accountability.

Siegel, C., Haugland, G., & Davis-Chambers, E. (2007). ***Cultural competency methodological and data strategies to assess the quality of services in mental health systems of care: A project to select and benchmark performance measures of cultural competency.*** **New York, NY: Nathan Kline Institute for Psychiatric Research. Retrieved from http://csipmh.rfmh.org/other_cc.pdf**

This report presented benchmark performance measures and recommendations for increasing mental health systems' responsiveness to multicultural populations. A conceptual framework identified five performance measure domains: 1) needs assessment, 2) information exchange, 3) services, 4) human resources, and 5) policies and plans. The framework also included three key organizational levels involved in culturally competent services: 1) administrative, 2) direct care/service, and 3) individual.

Domestic Violence- and Sexual Assault-Related Services

Brade, K. A., & Bent-Goodley, T. (2009). A refuge for my soul: Examining African American clergy's perceptions related to domestic violence awareness and engagement in faith community initiatives. ***Social Work and Christianity, 36,*** **430-448. Retrieved from http://www.nacsw.org/SWCFull.pdf**

Introduction
This article discusses the importance of Christian faith-based clergy and their critical role in the informal help-seeking network for domestic violence survivors. Existing literature suggested challenges in acknowledging domestic violence and engaging in practices that are effective for addressing domestic violence in African American communities. The article aims to fill a gap in the literature on African American religious leaders' perceptions surrounding domestic violence intervention initiatives by describing African American clergy's perceptions of domestic violence awareness and engagement in domestic violence initiatives within faith communities.

Methods
The research in this article is part of a larger study that explored the domestic violence-related

perceptions and experiences of a sample of African American clergy enrolled in graduate theological studies (140; 88 females, 52 males). The exploratory study used a convenience purposive sample, which completed a questionnaire packet that asked about participants' demographic characteristics, experiences dealing with domestic violence as clergy, and perceptions about domestic violence generally and in faith communities specifically.

Results
The majority of participants believed that domestic violence is a concern of the church; felt that religious beliefs were not protective against domestic violence; and knew someone in their congregation who had experienced interpersonal violence. Over 70% of participants thought that worship services should address domestic violence through prayer, sermons, and litanies. Most participants (over 84%) felt that the church was not adequately equipped to assist members dealing with interpersonal violence; that the church needed more educational resources and training to respond to domestic violence; and that more support was needed from social agencies, government agencies, and laws.

Conclusions and Implications
The findings revealed that Christian faith leaders were aware of domestic violence in faith communities and perceived a need for more resources, services, and involvement within and outside of the church to adequately respond to domestic violence. Heightening social workers' and clergy's awareness and engagement in domestic violence prevention and intervention initiatives in faith communities, particularly in faith communities of color, were recommended.

Gondolf, E. W., & Williams, O. J. (2001). Culturally focused batterer counseling for African American men. *Trauma, Violence, and Abuse, 2*, 283-295.

Introduction
The study assessed the effectiveness of culturally-focused counseling for African American men who had perpetrated domestic violence. The study examined differences between culturally focused, culturally sensitive, and culturally competent approaches.

Methodology
The clinical trial included a sample of 503 African American men who had been arrested for domestic violence. Quantitative data on assaults and arrests after counseling were collected.

Results
The study found no differences in re-assault and re-arrest rates among African American men in culturally-focused counseling and in conventional counseling for the African American group and the racially-mixed group.

Conclusions and Implications
Culturally-focused counseling is a more structured and systematic approach to addressing cultural differences than culturally sensitive or culturally competent counseling. Culturally sensitive counseling deals with awareness to the cause of violence. Cultural competence refers to demonstrated skill and experience with participants of a different racial backgrounds as well as establishment of structural supports that ensure cultural information is available to deliver effective care.

Hampton, R. L., LaTaillade, J. J., Dacey, A., & Marghi, J. R. (2008). Evaluating domestic violence interventions for black women. *Journal of Aggression, Maltreatment & Trauma*, *16*, 330-353.Traditional intervention approaches and advocacy, criminal justice, and law enforcement efforts to respond to domestic violence in African American communities may be ineffective for African American women, who particularly need culturally sensitive supports. Systemic racism and oppression are barriers to disclosing abuse and accessing resources, and culture-blind interventions often have been the available services for African American women. This article examines the use of restorative justice approaches that address the needs and concerns of victims, perpetrators, and the larger community to eliminate violence. This approach can help increase cultural sensitivity and increase the effectiveness of interventions for Black women who have experienced violence.

Puddy, R. W., & Wilkins, N. (2011). *Understanding Evidence Part 1: Best Available Research Evidence. A Guide to the Continuum of Evidence of Effectiveness.* Atlanta, GA: Centers for Disease Control and Prevention.

The aim of this guide is to explain Continuum of Evidence of Effectiveness, which clarifies and defines standards as well as adds to the evidence base in violence prevention. The guide notes that experiential evidence, best available research evidence, and contractual evidence are important for decision making. The Continuum is based on two underlying factors of the best available research evidence: strength of evidence and effectiveness of the desired outcomes. The guide provides a list of six dimensions that make up the Continuum of Evidence of Effectiveness: 1) effect, 2) internal validity, 3) research design, 4) independent replication, 5) implementation guidance, and 6) external and ecological validity. Definitions, examples, and uses of the dimensions are discussed.

Stennis, K. B., Fischle, H., Bent-Goodley, T., Purnell, K., & Williams, H. (2015). The development of a culturally competent intimate partner violence intervention-START©: Implications for competency-based social work practice. *Social Work and Christianity, 42*, 96.

This article describes the development of the S.T.A.R.T., a religiously-sensitive and spiritually-based, multi-dimensional intimate partner violence (IPV) education and intervention model. S.T.A.R.T. evolved from community members' experiences, reflections, discussions, and training sessions. The components of S.T.A.R.T. are Shatter the Silence, Talk About It, Alert the Public, Refer, and Train Yourselves and Others. The model was developed in 2000 and has been tested and implemented to train African/African American and Hispanic Christian faith and community leaders, students, and practitioners. The article discussed findings that faith leaders are important responders for women of color who experience IPV but that women of color tend to avoid speaking out about their experience because conversations about IPV in faith communities is considered taboo. The authors concluded that the growing awareness of IPV among faith communities necessitates the development of culturally- and spiritually-competent interventions that are sensitive to the cultural nuances of diverse groups, such as the S.T.A.R.T Education and Intervention Model.

Sullivan, C. M. (2012, October). ***Examining the work of domestic violence programs within a "Social and Emotional Well-Being Promotion" conceptual framework.*** **Harrisburg, PA: National Resource Center on Domestic Violence.**

This article examines the work and effectiveness of domestic violence programs within a Social and Emotional Well-Being Promotion conceptual framework. The article discusses the predictors of and pathways to well-being and how these need to be addressed to provide the best care for domestic violence survivors. To support the empowerment and healing of survivors, community, social, and societal contexts that influence individual social and emotional well-being must be considered. Specifically, eight common features of domestic violence services are presented. Services that promote social and emotional well-being of survivors and their children: 1) Provide information about survivors' rights; 2) Develop safety plans; 3) Build skills; 4) Offer encouragement, empathy, and respect; 5) Provide supportive counseling; 6) Increase access to community resources; 7) Increase social support and community connections; and 8) Incorporate community change and systems change work. The goal of these program activities is to produce intrapersonal changes and interpersonal/social changes. Intrapersonal predictors of well-being include self-efficacy and hope. Interpersonal predictors include social connectedness and positive relationships with others; safety; physical, emotional, and spiritual health; adequate resources; and social, political, and economic equity. This examination of domestic violence programs found promising and positive outcomes for survivors who participated in programs with a holistic approach to well-being. Women noted that the services prevented homelessness, prostitution, and suicide attempts. The article concluded that the Social and Emotional Well-being Promotion framework, therefore, reflects the mission of domestic violence programs to help survivors and their children thrive, and provides a useful model for organizing and articulating how these programs promote the well-being of survivors and their children over time.

Williams, O. J. (2007). ***Supervised Visitation: Concepts in Creating Culturally Responsive Services for Supervised Visitation Centers.*** **St. Paul, MN: IDVAAC. Retrieved from http://idvaac.org/media/pubs/SuperVisitBook.pdf**

Recognizing the feelings distrust, fear, or being misunderstood that members of historical minority communities may have toward formal social services (as opposed to informal community helping and support networks), this report offered consumer- and stakeholder-driven recommendations to strengthen culturally responsive service delivery in supervised visitation. The report outlined the three stages of cultural responsiveness: culturally resistant, color blindness, and culturally responsive. At the culturally responsive stage, practitioners continually examine themselves and their behavior to determine how their attitudes and feelings influence their decision making; maintain self-awareness and self-evaluation; view their role with the clients from diverse communities as both teacher and learner; exhibit cultural humility; and encourage a partnership with their clients. The report described a number of characteristics of culturally relevant services, including: understanding cultural contexts of presenting problems and concerns; offering flexible hours; offering bilingual practitioners or services; providing a cultural broker who advocates for clients; conducting "indigenous intakes" that explicitly consider and explore clients' cultures; matching clients and staff appropriately; ensuring the agency environment reflects the cultures of populations

served; engaging natural helpers/systems; conducting culturally relevant assessments; and understanding clients' traditions and customs.

6. Conclusions

As "one-size-fits-all" approaches to domestic violence services do not effectively support African American communities, this annotated bibliography presents research to inform the development and implementation of evidence-informed, tailored, culturally responsive care for African American/Black survivors of domestic violence, their families, and communities. Examination of promising practices for serving culturally specific populations; ensuring culturally competence in systems, organizations, and services; and providing culturally responsive and specific domestic violence services is useful for researchers, practitioners, policymakers, community leaders, and community members. The literature in this annotated bibliography can provide guidance to most effectively respond to and work to prevent domestic violence in African American communities.

Insights from Existing Literature and Themes Related to Cultural Competency

Existing literature revealed a number of themes related to cultural competency. First, although there was a lack of consensus in terminology to conceptualize cultural competency, existing research has moved from an individual focus on cultural competency development to a multilevel focus that includes accountability and best practices at the individual to systems and community levels to address barriers to adequate care. The various terms used in the field, such as cultural sensitivity, cultural responsiveness, cultural effectiveness, and cultural humility suggest practices and procedures at multiple levels as well as an ongoing process of development (i.e., cultural competency as a journey rather than a destination). At an individual service provision level, best practices include providers' cultural flexibility and responsiveness; ongoing self-reflection and examination; thorough understanding of social contexts; core cultural values; and intersecting intrapersonal, interpersonal, and environmental factors that influence behavior and relate to violence; interventions that address culturally-specific factors that may affect health related experiences and perceptions; matching intervention materials and messages to the characteristics and preferences of the communities served; culturally diverse providers that reflect the populations served; coordinating with traditional healers; and involving family members in care. Organizational best practices involve leadership and the workforce. Strategies include leadership commitment; integrating cultural competency into organizational values and mission, policies and procedures, governance, hiring and retention practices, planning, and infrastructure; developing culturally and linguistically appropriate health education materials and ensuring language access services such as interpretation and translation; institutionalizing ongoing training and professional development of providers; and systematically monitoring and evaluating cultural competency, effectiveness of interventions, and quality of care to diverse populations. On a systems and community level, best practices involve integrating cultural competency into all existing health-related systems, community assessments and feedback, and engaging in efforts to sustain change (e.g., Anderson et al., 2003; Betancourt et al., 2002; Betancourt et al., 2003; Ferguson & Candib, 2002; Napoles-Springer et al., 2005; Resnicow et al., 1999; Sullivan, 2012; Wilson-Stronks et al., 2008).

The expanded focus on cultural competency suggests community buy-in and public demand to provide quality services to diverse populations. The current literature discusses cost-benefits to providing culturally competent care and that a key principle of successful cultural competency is making the business case for undertaking cultural competency initiatives for sustainability of high quality services (e.g., Goode et al., 2006; Wu & Martinez, 2006). The evolution from individual- to system-level cultural competency and an emphasis on an understanding of intersecting factors that are particularly relevant for individuals who have experienced domestic and gender-based violence indicate an expanded concept of responsibility to provide high quality, effective domestic violence services and supports to diverse communities. This expanded responsibility includes increasing engagement of community supports and natural helpers including faith- and culture-based organizations (e.g., Williams, 2007). Given their unique and trusted role in the African American community, it is important to increase clergy's awareness, resources, and capacity to respond to domestic violence. Faith communities and congregations can serve as advocates and activists to end domestic violence (Brade & Bent-Goodley, 2009; Gillum, 2009). While leveraging the strength of faith in addressing domestic violence, prevention and intervention experts must consider spiritual/religious values, norms, and teachings that may increase risk and serve as barriers to addressing domestic violence in order to thoroughly equip the faith community to appropriately respond (Abugideiri, 2011; Stennis et al., 2015). It also is critical to engage individuals experiencing domestic violence as partners, designing materials in collaboration with populations served, engaging survivors in empowerment and activism efforts, and involving both men and women in advocacy and the demand to end domestic violence (e.g., West & Johnson, 2013; Williams, 2007). Such efforts will help ensure a continuum of domestic violence prevention and intervention resources for African Americans.

Another theme in the literature is related to service recipients' perceptions of quality, culturally responsive care. Culturally specific and tailored interventions and curricula consider culture-specific values, norms, attitudes, expectations, and customs of the populations served. Principles of quality in domestic violence services include safety, equity, effectiveness, and survivor-centeredness and partnership. Additionally, holistic approaches are critical for comprehensive care, expanding conceptualization of health to include physical, mental, emotional, and spiritual aspects as well as understanding social, political, economic equity in relationship to violence. Particularly for African Americans, it is important to recognize potential feelings of mistrust, fear, disconnection, or misunderstanding toward formal social services and therefore provide supports that feel safe, comfortable, relevant, and respectful. Individuals who participate in culturally-specific interventions have reported greater satisfaction than with services considered mainstream or that did not incorporate their cultural experiences, needs, and resources. Services recipients have had positive outcomes and impressions of services that were sensitive to and incorporated individuals' values, beliefs, and preferences (e.g., spiritual, familial); respectful; sensitive to how survivors navigate their relationships; and welcoming, supportive, and accessible. Related to the quality, relevance, and perception of services are the necessity of developing strengths-based interventions that bolster the resiliency of African Americans. Interventions that focus on healing and incorporate music, art, activism, and empowerment strategies, for example, may be powerful and effective. These experiences underscore the importance of culturally- and spiritually-competent interventions as well as the necessity of empathy, connection, and rapport in addition to expertise in violence and trauma (e.g., Betancourt, 2006; Ferguson & Candib, 2002; Gillum,

2009; Johnson et al., 2004; Napoles-Springer, 2005; Sullivan, 2012; West & Johnson, 2003; Williams, 2007).

Gaps in the Literature

The reviewed literature identified and intended to fill gaps related to continued barriers to supports for survivors of domestic and gender-based violence, research, and practice. Regarding barriers to accessible and culturally responsive services, certain communities have experienced particular unmet needs. African American women who have histories of sexual assault and other trauma, incarcerated women, and women from under-resourced communities need a greater safe space and encouraging environment to share their experiences, receive support, and build upon their strengths to thrive. Clinical trials of women who have experienced abuse and who have been suicidal were recommended to increase understanding of these populations. Other special populations and needs include formerly incarcerated men and reentry planning that considers family violence, people living with HIV/AIDS, rural or geographically and socially isolated communities, and LGBT communities. More research on child maltreatment, children's exposure to violence, and the efficacy of domestic violence services on children's well-being also is recommended.

Further research is necessary to thoroughly understand the intersectionality of individual to sociocultural factors and health outcomes. Such research includes examinations of racial, ethnic, and socioeconomic disparities; definitions, components, and measurement of multilevel cultural and linguistic competence; service recipient outcomes and efficacy of cultural competency strategies and interventions; and cost-benefits of culturally competent, responsive, and specific services. Enhanced data quality and reliability of statistics related to race and ethnicity are needed. Gaps in evidence on the impact of culturally competent services on health and service outcomes as well as the effectiveness of culturally-specific and focused interventions remain.

Additionally, further development of practice is required to fill gaps in quality, culturally responsive care. Current research recommends development of community-based services that consider issues such as poverty, racism and discrimination, and service accessibility. The intersection of racial identity, cultural identity, and gender identity; what group membership means; and experience with services and systems also should be considered. As many existing domestic violence services are mainstream and not culturally-specific or culturally-focused, further research is needed on interventions designed for African Americans and other communities of color to determine their effectiveness. Furthermore, to add to the body of research on intimate partner violence among African Americans in the context of faith, further examinations of the role of faith and faith-based and community leaders in supportive services are needed. Systematic and ongoing evaluation studies of the impact of culturally specific and relevant services on the health of African Americans also are necessary to continue to refine and expand interventions. Studies of the long-term effects of domestic violence programs on populations served are further recommended.

Recommendations for Future Directions and Quality Services for African Americans

To respond appropriately to domestic violence, interventions must be trauma-, survivor-, culturally-, and evidence-informed. The complexity of historical and contemporary contexts of African Americans; appreciation of diversity; and the barriers, risks, strengths, and resiliency related to the impact of domestic violence are vital to understand and integrate into effective domestic violence prevention and intervention efforts for African Americans. Based on the existing literature, the following strategies are recommended to ensure the availability of the highest quality and most effective domestic violence services and supports for Black/African American communities in particular and all diverse communities more broadly.

Understanding and conceptualization of cultural factors

- Increase the understanding in the field of people's racial, ethnic, and cultural identities and their interpretation of what membership in these groups represents for them.
- Increase understanding of the diversity within African Americans communities and strategies to tailor interventions to the needs and strengths of populations within the African American community to best serve them; underserved populations include LGBT, various faith communities, male survivors of domestic violence; and incarcerated and reentering individuals.
- Encourage providers' understanding and reflection of how their own values and norms may contrast with service recipients and affect care.
- Increase understanding of feelings of trust or distrust; experiences of discrimination and racism; perceptions of bias; cultural values, norms, and messages; and other experiences that may affect African Americans seeking and receiving domestic violence services, sharing their experiences, or participating in research.
- Develop validated and shared definitions and frameworks of cultural competence and expand conceptualizations of culture (e.g., beyond race, ethnicity, or language).

Evidence-informed services

- Treat service recipients as equal partners in their care to ensure culturally responsive and tailored services.
- Consider the balance between fidelity to evidence-based practices and culturally-specific and culturally-focused adaptations to provide quality care to diverse populations, and use performance measures and benchmarks to monitor fidelity and adherence to practices to effectively serve culturally diverse populations.
- To reduce multilevel barriers to quality care, culturally competent interventions should include organizational, structural, clinical, and systemic components.
- Create policies, procedures, accountability measures, and leverage resources to infuse ongoing cultural competency development and sustain efforts to provide culturally responsive services.

Research and data

- Enhance the quality, reliability, completeness, and availability of data on racially, ethnically, and linguistically diverse populations.
- Collect and use community- and service recipient-level data to measure, monitor, and evaluate the quality, effectiveness, and utilization of culturally responsive services.

- Conduct longitudinal and large sample studies to determine the short- and long-term effects of culturally competent, responsive, and specific services on the health and well-being of survivors of domestic violence.
- To inform culturally responsive care, research interactions and intersectionalities among factors that can affect individuals' health, experiences, behaviors, and resources (e.g., cultural and social contexts, spiritual and religious beliefs, interactions of providers and patients from racially/ethnically diverse backgrounds, histories of trauma, intergenerational factors, racism and discrimination, socioeconomic factors).
- Continue to thoroughly examine the unique strengths, needs, historical contexts, and relationships of the diverse communities within the African American population, including individuals from various geographic regions (e.g., Southern U.S., rural, urban), sexual minority communities, and faith communities. Expanding research on diverse African American communities will increase representativeness and generalizability of findings.
- When delivering services, address issues that intersect with domestic and sexual violence among African Americans, including health disparities, child maltreatment, HIV/AIDS and other sexually transmitted diseases, historical trauma, spirituality, and community support.

Community involvement and response

- Build partnerships among organizations, agency and institution departments, providers, individuals, community representatives, and champions of culturally and linguistically appropriate care to develop and advance culturally responsive services to African American communities.
- Consider cost savings and implications in safe, quality culturally responsive care to build the business case for culturally responsive services, programs, and organizations.
- Involve community members and service recipients in every aspect of care – from design, to implementation, to evaluation.
- Seek leaders of community groups to solicit concerns and recommendations about responsive, high quality domestic violence services for diverse populations.
- Engage and prepare (e.g., through training, collaboration with social workers, educational material) trusted community leaders and institutions such as clergy, lay leaders and congregants in places of worship, and community- and culture-based organizations to provide domestic violence support services.
- Engage diverse stakeholders including practitioners, researchers, policymakers, educators, activists, families experiencing domestic violence, community- and faith-based organizations, and the larger community to serve as advocates to prevent domestic violence.

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