California Initiative for Health Equity & Action (Cal-IHEA)
HEALTH POLICY REPORT

State Innovation to Prevent the Recurrence of Intimate Partner Violence

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Executive Summary

More than 1 in 3 women (35.6%) and 1 in 4 men (28.5%) in the United States report experiencing a form of intimate partner violence (IPV) in their lifetimes, and women of color, especially Indigenous and Black women, report this at higher rates.[1] Despite the widespread impact of IPV, public health-oriented programs and initiatives to intervene before violence occurs are not widely available and used, or they are largely understudied and underfunded. Currently, batterer intervention programs (BIPs) serve as the primary intervention for those who cause harm and are designed to hold individuals who cause harm accountable and engage them in changing their behaviors. In California, these programs are mandated and overseen by law enforcement agencies, which results in these programs having a criminal-legal orientation. Over the past several years, other states have innovated in the delivery of BIPs by implementing public health-oriented practices and policies that may have a greater impact on preventing the recurrence of IPV. In this report, we examine these innovative, public health-oriented practices and policies that California could learn from to re-imagine how to prevent IPV across the state.

Policy Recommendations:

1. Invest in mitigating structural risk factors for partner violence.
2. Increase pathways for early intervention.
3. Establish an agency within the California Department of Public Health (CDPH) that is responsible for collaborating with stakeholders and overseeing IPV prevention and intervention efforts.
4. Initiate dedicated state funding for community-based organizations (CBOs) to implement intervention programs and provide wraparound support.
5. Reimagine intervention programs to be restorative and culturally-specific.
6. Collect and evaluate program outcome measures.

Introduction

Though intimate partner violence (IPV)* is often perceived to solely be an individual problem, poverty, racism, and patriarchal social norms contribute to the social environments that tolerate and perpetuate gender-based violence and IPV. These factors also influence childhood trauma, economic instability, toxic masculinity, and substance use; these shape the conditions under which an individual may be more likely to harm their partner.[2,3]

Mitigating these upstream risk factors of violence and preventing abusive behaviors are essential to prevent the recurrence of IPV, yet neither is the focus of major legislative initiatives. Federal efforts to address IPV include the 1984 Victims of Crime Act, which provides federal support to state and local programs that assist victims of crime; the 1984 Family Violence Prevention and Services Act (FVPSA), which established the primary federal funding stream dedicated to the support of emergency shelter and related assistance for victims of IPV and their children; and the 1994 Violence Against Women Act (VAWA), which led to the creation of the Office on Violence Against Women (OVW), established federal programs to support survivors of IPV, provides protections for undocumented women, and funds housing and lawyers for civil matters.[4] These efforts have been critical to bolstering necessary supports for survivors of IPV, but have done little to mitigate upstream risk factors and prevent the initial occurrence of IPV. Additionally, VAWA has been criticized for its role in ensuring that criminalization is the primary response to IPV, due to a significant portion of VAWA funding funneling to the criminal-legal system† and OVW's grant programs that support coordinated response tactics between survivor-serving entities and law enforcement.[4]

In addition to the minimal funding allocated to addressing upstream risk factors of IPV and mitigating abusive behaviors, the involvement of the criminal-legal† system in IPV response results in the low impact of current IPV interventions; this is due, in part, to the strained relationship between some communities and police, the first responders of the criminal-legal system. Undocumented, immigrant, Black, Brown, Indigenous, and lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) communities are often victims of over surveillance, harassment, and police brutality, which has led to and reinforced mistrust of law enforcement in these communities.[2] Many survivors of IPV are already reluctant to involve the criminal-legal system. A study published by the Bureau of Justice Statistics found that between 2006-2015, 44% of partner violence incidents went unreported, highlighting low trust in the criminal-legal agencies responsible for protecting survivors.[5] When violent incidents are reported, many survivors found that the criminal-legal system is unable to provide necessary support.[6] In a recent survey conducted by the Blue Shield of California Foundation, one third of

** We use the term intimate partner violence (IPV) instead of domestic violence (DV) to describe forms of partner violence regardless of sexual orientation, marital status, or gender. The term domestic violence (DV) is primarily used in the criminal-legal system to describe forms of violence within relationships, but the term originated from and is associated with abuse in a heterosexual marriage. It can also be used to describe violence involving children and other family members within the household.*

† The criminal-legal system is frequently referred to as the 'criminal justice system'. This term implies that criminality is the path to justice. We opt to instead use the term 'criminal-legal system' as an objective term to encompass police, courts, and corrections departments.

Californians said they would either not go to the police if they were assaulted or think that police officers would make the situation worse.[7] The survey also showed that 79% of Californians support alternatives to jail for people who cause domestic violence. These findings suggest that the criminal-legal orientation to IPV interventions may prevent survivors from seeking assistance, rendering the current system of mitigating IPV ineffective. Instead, a more holistic, public health framework that is focused on addressing survivors' needs and the risk factors for IPV may stimulate greater trust in the state government's ability to mitigate the impacts of IPV.

Batterer Intervention Programs

Initiated in California in 1994, certified batterer intervention programs (BIPs)[‡] are mandated for individuals convicted of domestic violence (DV) or IPV. Across the country, these programs are designed to hold individuals who cause harm accountable and engage them in changing their behaviors. BIPs have the potential to be a key component of a public health approach to IPV, yet the positioning of these programs within the criminal-legal system in California limits their ability to address upstream determinants of violence or act as a preventive intervention, since they are often presented as an option only after an individual has been convicted of DV.

Over the past several decades, research studies have produced conflicting results regarding the effectiveness of court-mandated BIPs in reducing violence and changing behavior. In one study, a review of 30 BIPs found positive outcomes of BIPs, demonstrating that men who completed BIPs are less than half as likely as men who did not to be rearrested for DV.[8] Another study found that men sentenced to jail after being convicted of DV were more likely to be rearrested than those mandated to attend BIPs.[9] However, studies that have found positive effects of BIPs often have methodological deficiencies, such as small sample sizes, short follow-up periods, or no control groups.[10,11] Experimental and quasi-experimental studies are more rigorous, yet often find no difference in recidivism rates among groups of men who have attended a BIP and those who have not.[12–14] Most recently, a systematic review found that experimental and quasi-experimental studies show modest but not statistically significant benefits for the program group, and thus there is insufficient evidence to conclude that BIPs are effective.[15]

Ultimately, the sum of research outcomes suggests that existing BIP programs may not be effective, and new approaches to intervention delivery could be more successful in engaging participants voluntarily and reducing recidivism. Though detailed statistics on BIP participants are not collected by the state of California, research suggests that participants are most often men, have a low-income background, and are more likely to be people of color.[16] These and other social and environmental factors can impact the occurrence of IPV, and therefore IPV may be best addressed through a public health approach that addresses the risk factors for violence and provides wraparound services that promote participation. This approach could allow BIPs to serve as a preventive intervention to IPV. In this brief, we examine innovative, public health-

[‡] *In efforts to reframe IPV as a public health issue, several states have intentionally chosen to avoid language that stems from the criminal-legal system, including perpetrator and batterer, which stigmatize the individual rather than their behavior. Throughout this report, we use each state's preferred terminology when referring to their specific program, and we use California's terminology, Batterer Intervention Program (BIP), when referring to intervention programs generally for ease of understanding. However, we support inclusive terminology that is person-first to be recognized across all IPV interventions.*

oriented practices and policies that California could learn from to re-imagine how to prevent IPV across the state.

Summary of Methodology

Our research began with a landscape analysis of BIPs and services across the United States. Based on documented innovations in BIP delivery, we selected the states of Massachusetts, New York, Oregon, Texas, and Washington for in-depth analyses. From May to July of 2021, we conducted 21 interviews with key stakeholders of organizations involved with administering BIPs, advocacy coalitions, and community-based IPV prevention programs. In these interviews, we discussed program administration, accreditation, funding, monitoring and evaluation, wraparound supports, and other program- and state-specific topics.

Best Practices

Similar innovative practices and policies were implemented across the five states we considered, enabling a transition from punishment-oriented interventions toward trauma-informed, whole person interventions in several. Outlined below, these best practices are important for California to consider implementing in order to improve the reach and effectiveness of IPV prevention efforts.

Secure State Funding

Across the five case study states in this analysis, we found that secure state funding promoted the accessibility of intervention programs. When state funding is available to subsidize a portion of program costs, programs are able to charge lower participant fees, making participants more likely to be able to attend.[17] Not only does the affordability encourage participation and prevent individuals from not meeting the terms of their probation for non-payment, but it also may reduce barriers to entry for individuals who are not mandated by court to attend but could still benefit from voluntary program participation.

In the 2019-20 fiscal year, approximately $40 million of the Massachusetts' state budget funded Domestic Violence and Sexual Assault Prevention and Treatment, of which approximately $1.5 million was allocated to supporting state-certified Intimate Partner Abuse Education Program (IPAEP) Services.[18] On average, this funding subsidized 10-15% of program costs, depending on the budget of the program's overseeing organization. The budget allocation was raised to $50 million in fiscal year 2021, and it is expected that a higher amount will be allocated to subsidizing IPAEP services as well.[18] In Texas, select accredited Batterer Intervention and Prevention Programs (BIPPs) that provide services in an underserved area are partially funded by the state. The Texas Department of Criminal Justice-Community Justice Assistance Division (TDCJ-CJAD) allocates funding using weighted program performance measures (audit scores, completion rates, and completion of activity and financial reports).[19] Funding for selected programs subsidizes approximately 30% of program costs, substantially decreasing the financial burden on participants and their families.

Pilot programs and alternative routes for program funding are actively being explored across the five states. Both the Texas Department of Family and Protective Services and the Washington

Department of Child Protective Services contract with individual BIPs to provide funding for clients who are referred through their services. In Washington, where the state does not subsidize individual programs, a pilot program in Whatcom County is combining city and county funds to cover Domestic Violence Intervention Treatment (DVIT) program costs for participants who cannot afford treatment; the funds are distributed by the probation department to individual DVIT programs through contracts and reimbursements. In Oregon, there are ongoing efforts to provide funding for BIPs, survivor support groups and services, and safety planning on a fee-for-service basis through Coordinated Care Organizations.[20] If approved, this funding could potentially reduce or eliminate participant fees. By comparison, in California, BIPs receive no funding from the state. Many charge substantial fees that prevent or limit participation from low-income individuals, who make up the majority of BIP participants. A recent study of BIPs in Los Angeles County found that although the law requires that programs charge sliding-scale fees, many do not do so.[17]

Centralized Administration by Agencies Outside the Criminal-Legal System

Of the five states analyzed, four (Massachusetts, New York, Oregon, Washington) have deemed a centralized state agency outside of the criminal-legal system responsible for either overseeing or providing recommendations for BIPs. Most often housed within a state's department of public health (or an equivalent department), this positioning directs the agency to utilize public health resources and streamline care coordination.

The Intimate Partner Abuse Education Program (IPAEP) Services unit, housed within the Massachusetts Department of Public Health, is able to collaborate with other arms of the department as well as other departments that fall under the Executive Office of Health and Human Services, including the Massachusetts Department of Children and Families (DCF) and the Bureau of Substance Addiction Services. The goals of these collaborations are to more efficiently make referrals and resource recommendations to clients and reduce barriers to necessary treatments. In Washington, the Department of Social and Health Services (DSHS) oversees DVIT programs, allowing DSHS to form connections between DVIT programs and other social and health support services that would benefit clients and their families.

The New York Office for the Prevention of Domestic Violence (OPVD), an independent executive level agency, does not currently provide oversight or accreditation. However, the agency is uniquely positioned to do so, having determined best practices and monitored state trends with a sharp focus on preventing DV over the past three decades.[21] As of July 2021, the state is in the process of deciding whether or not to implement a formal accreditation process; should they proceed with accreditation, the existence of OPVD could support a seamless transition to increased centralization.

In regions with centralized administration in the criminal-legal system, we found that it is possible to integrate community-centered approaches. In Oregon, though the Attorney General has the authority to establish standards for BIPs and local corrections agencies are responsible for screening and approving BIPs, each county has a domestic or family violence council that

fosters a coordinated community response in alignment with community cultural norms and values.[22] In California, there is an opportunity to similarly initiate additional county-level councils to expand culturally-specific and community-oriented BIPs.

Tailored Programming and Services

BIP curriculum and program guidelines are broad in many states, which allows programs to modify their curriculum and delivery according to their community's needs. In particular, an increasing number of organizations have tailored programs for their community's identity, culture, and values. For these groups, facilitators who share the same identity as group participants are considered critically important to fostering a supportive environment.

For example, Washington state guidelines require each program to use a trauma-informed cognitive behavioral approach to DV and IPV prevention. Within these guidelines, programs in indigenous communities are able to integrate cultural values and perspectives into the curriculum to connect with individuals most effectively. Drawing on cultural underpinnings of harm, power, and relationships, program facilitators aim to connect with the individuals through shared experiences and generational knowledge.

Similarly, certain demographic groups benefit from having distinct spaces. In each of the five states, several BIP providers offered separate LGBTQ+, youth, and womens' programs. Program facilitators voiced that using gender-inclusive language and addressing unique relationship dynamics and societal circumstances in these groups is useful to relate back to abusive thought patterns and behaviors.[21] Additionally, research has shown that participants are more engaged when the program content is applicable to their personal situation. [23,24] In Oregon, BIPs for women are separately administered by the Department of Human Services (DHS) rather than the Office of the Attorney General and the BIP Advisory Committee, and they offer more robust wraparound services for participants, such as childcare during programs and mental health services. Oregon is now trending towards multi-gendered programs that incorporate wraparound services and a public health approach, as modeled by Oregon's womens' programs.

Another form of tailoring, demonstrated in Washington, is tiered programming. Participants are assigned to one of four levels of treatment based on results of their intake evaluation. Their treatment level is determined by an assessment of various criteria, including risk for recidivism, previous DV charges, and criminogenic needs.[25] This form of differential treatment improves the effectiveness of BIPs by targeting treatments to participants' needs.[26] Six counties in California are currently piloting a similar approach as part of AB 372, with individuals in participating programs being assigned to a program length based on their risk and needs assessment. [27] In Texas, some programs offer a "high risk track" for repeat offenders or those who otherwise need more intense intervention. These various forms of tailoring push against the "one-size-fits-all" approach to be more inclusive of participants' specific needs.

Interorganizational Agreements and Coordination

Collaboration among community organizations within the DV sphere is critical to ensuring that BIPs are informed by the perspective of survivors and members of the community. Coalitions

that are inclusive of advocates, program leaders, and relevant state agencies set the stage for ongoing conversations and innovations that improve the delivery of BIPs. In Texas, although the programs are overseen primarily by an agency within the criminal-legal system (TDCJ-CJAD), a partnership between the state agency and a designated nonprofit organization is written into State code to ensure longevity.[28] The nonprofit organization, Texas Council on Family Violence, convenes advisory committees inclusive of advocates and survivors to provide program recommendations and guidance, ensuring that programs utilize trauma-informed practices to promote victim safety. Additionally, TDCJ- CJAD works closely with local probation offices to encourage coordination between local BIPPs and other DV programs or initiatives.

In Oregon, the BIP Advisory Committee, housed within the Crime Victim and Survivor Services Division, provides consultation and recommendations to the Attorney General. The committee includes statewide DV coalition leaders, community practitioners, and advocates, again lending a greater breadth of perspectives.

Similarly, though Washington's DVITs are overseen by DSHS, the Washington State Domestic Violence Intervention Treatment Program Standards Advisory Committee provides program recommendations and guidance. Additionally, all stakeholders - including the Washington State Coalition Against Domestic Violence, DSHS, program leaders, and probation officers - take part in monthly meetings where they share updates on their programs, enrollment, challenges, and other relevant information. These meetings strengthen the relationships between various organizations, allowing them to work together cohesively and communicate effectively across the field of DV intervention work.

What Can California Learn from the Five States?

Current Landscape of Batterer Intervention Programs

Since 1994, California law has required defendants who are convicted and granted probation in DV cases to complete a BIP. However, in part due to inconsistent program models and a lack of data on program outcome measures, they have had low completion rates, have little impact on recidivism and participant attitudes/behavior, and often place a financial burden on families due to being funded by fines and fees.[16] The state's system of program oversight and accreditation is highly decentralized; California Penal Code §1203.097, which outlines the length and curriculum requirements for BIPs, gives individual probation departments the authority to certify and renew BIPs within their jurisdiction.[29] This leads to variations in assessment, certification, and evaluation procedures between counties, resulting in large discrepancies in BIP implementation and success. Additionally, the programs are often informed through a heteronormative lens and are not typically culturally relevant or responsive.

California's Assembly Bill 372 (Stone, 2018) allows six pilot counties to implement alternative approaches to treating DV offenders through flexibility in program modality and length, or dosage.[30] Pilot programs are required to meet certain conditions, such as performing a risk and needs assessment that determines program dosage and including specified evidence-based modality practices.[30] The use of algorithmic risk assessments to determine program dosage raises concerns of exacerbating inequities based on race. Additionally, the six counties use four

different risk assessment tools, resulting in possible variation in what is considered 'high' versus 'low' risk across counties. Furthermore, BIPs in these pilot counties still operate within a criminal-legal system that is based in punishment and compounds racism, violence, and harm more broadly. Pilot program outcomes are expected to become available in early 2022 and will provide an assessment of how the new program models work and whether these concerns present in practice.

Innovations that California Policymakers Should Explore

In order to prioritize a public health approach to addressing IPV, California should invest in alternative innovations that do not primarily rely on the criminal-legal system. The majority of the following recommendations are rooted in practices that other states have found to be transformative in engaging individuals who cause harm to others.

1. Invest in mitigating structural risk factors for partner violence.

Recognizing IPV as a public health issue requires California to identify and mitigate both community and individual-level risk factors. At the community level, research has found that low social capital, poverty, and poor neighborhood cohesion are linked to higher incidences of IPV, as are unemployment, poor mental health, substance use, and childhood trauma at the individual level.[31] Research has demonstrated that through affordable housing initiatives, expanding employment opportunities, making childcare more accessible, and increasing family supports, the state can begin to mitigate issues of economic instability among low-income families.[32–34] Through community-based mental health clinics and crisis stabilization units, individuals can access mental health and substance use treatment in a reliable and timely manner.[35,36] Similar efforts to address IPV risk factors can reduce the initial occurrence of harm.

2. Increase pathways for early intervention.

BIPs are primarily utilized after conviction in California, but they could serve as a preventive and educational intervention if encouraged prior to arrest and modified appropriately. There have been conflicting findings regarding the efficacy of voluntary participation; one study found that court-mandated participants show an increased risk of recidivism, while a more recent study found no significant differences in recidivism outcomes between mandated and voluntary BIP participants.[37,38] Still, increasing community awareness of and pathways to intervention programs may promote agency and help-seeking behavior among those who cause harm to others. In a recent study, researchers found that over half of a BIP's participants had previously engaged with the local Department of Human Services (DHS) to access general welfare, health and medical assistance, and behavioral health services, and recidivism was higher among those with prior DHS involvement; these findings suggest that screening for IPV and providing pathways to intervention programs in these settings may be significant in reducing the occurrence of IPV.[39] Additionally, local public health departments can lead efforts to encourage voluntary participation in intervention programs by screening for IPV in healthcare clinics, school-based violence education programs, and partnerships with faith-based organizations. The state can require training that is informed and approved by the DV advocacy community for school counselors, social workers, mental health specialists, medical personnel, and court

personnel (e.g., judges, prosecutors, probation officers, guardian ad litem) with the goal of expanding the availability of services in which the staff are trained to respond appropriately to cases involving IPV and for mental and medical health professionals to engage in appropriate screening and referral.

3. Establish an agency within the California Department of Public Health (CDPH) that is responsible for collaborating with stakeholders and overseeing IPV prevention and intervention efforts.

Several programs and initiatives focused on reducing violence exist at the state level but are overseen by separate agencies.[40,41] Consolidating these programs in a centralized violence prevention and intervention agency within CDPH will streamline efforts to coordinate IPV services and funding while prioritizing a public health approach. The agency would accredit intervention programs and ensure standardization of program evaluation metrics. Additionally, the proximity of an agency within CDPH to other public health services should strengthen referral pathways across associated agencies, thereby promoting early intervention and care coordination.

This agency would **collaborate with existing coalitions** in California, such as the California Partnership to End Domestic Violence, to ensure that the standards for intervention programs are informed by survivors and advocates. To initiate the transition towards a statewide agency, California should **establish a public/private sector workgroup** consisting of survivors, people who have successfully completed a BIP, stakeholders from advocacy groups, CDPH, BIP providers, and probation officers who currently oversee county BIPs.

4. Initiate dedicated state funding for community-based organizations (CBOs) to implement intervention programs and provide wraparound support.

Through an allocation in the state budget, or other funding opportunities, intervention programs can become more affordable for participants and present a lower financial burden to the family, improving their reach and impact. Additionally, more affordable programs create a lower barrier for non-system involved individuals to seek intervention voluntarily, presenting an opportunity to correct abusive behaviors and address trauma before individuals enter the criminal-legal system. Programs that receive funding will also be able to increase their capacity to connect participants with wraparound support such as broadband access, transportation, and childcare, thereby allowing participants to better engage in the program and ultimately reduce recidivism.[8]

5. Reimagine intervention programs to be restorative and culturally-specific.

The flexibility to adapt intervention programs according to community identities, values, and needs can engage participants more effectively than a standardized approach. A centralized agency within CDPH can promote tailored prevention interventions by establishing curriculum requirements that are broad and allow for individualization. Intervention program providers can partner with existing cultural and faith-based community organizations to inform curricula,

and a centralized agency can redirect resources and initiate partnerships to address resource gaps and communities in need of linguistic, demographic, or culturally-specific programming. By incorporating cultural perspectives and acknowledging intergenerational trauma, which may be tied to forms of structural violence and in turn influence partner violence, cultural groups develop a community of healing rooted in shared values. Similarly, demographic groups with shared lived experiences are able to discuss their identity and shared challenges in relation to their behaviors and partner violence.

6. Collect and evaluate program outcome measures.

Though many states require programs to report outcome measures, these data are typically not evaluated or reported, making it difficult to measure the impact of program- or state-specific practices on BIP effectiveness. A future centralized IPV prevention and intervention agency at CDPH can be tasked with collecting, aggregating, and evaluating outcome measures from intervention programs across the state, which would allow examination of the comparative effectiveness of these programs.

Methodology

To identify innovative IPV prevention interventions, we conducted a landscape analysis of 10 states that were selected based on prior knowledge of and interest in innovations within those states. A broad grey literature review was completed to collect qualitative data on state BIP administrative agencies, accreditation processes, funding sources, social supports, state demographics, and monitoring and evaluation strategies. States were narrowed to Massachusetts, New York, Oregon, Texas, and Washington based on their unique innovations and relevance to California due to similar demographics, population size, or political landscape. An in-depth literature review was completed to characterize past state legislation, regional variations, and program standards. 21 informant interviews were conducted with key stakeholders of state agencies, individual BIPs, coalitions, and community-based IPV prevention programs. With overseeing agencies, we discussed program administration, accreditation, funding, monitoring and evaluation, wraparound supports, and other program- and state-specific topics. With coalitions, community-based prevention programs, and individual BIPs, we discussed culturally specific programming, interactions with other IPV stakeholders, data collection, and deviations in practice from BIP policy. Findings from the literature reviews and key informant interviews were analyzed to identify common themes and innovations, as well as opportunities for California to improve its BIP delivery.

Conclusion

Given the devastating and widespread impact of IPV, it is important for California to invest in effective interventions aimed at preventing the recurrence of partner violence both prior to and concurrent with involvement in the criminal-legal system. The existing primary intervention, BIPs, have not proven to be particularly effective, nor do they encourage individuals to seek intervention prior to arrest. Instead, programs developed using a public health framework may be more successful in preventing the recurrence of partner violence, ultimately reducing the impact of IPV on California's communities. The aforementioned policy recommendations

outline innovations that California may consider implementing in order to transition from punishment-oriented interventions toward trauma-informed, whole person interventions.

By leveraging what has worked well elsewhere, customizing approaches as needed, and taking the lead from advocates and survivors of IPV within California, the state has the opportunity to transform the delivery of IPV prevention and intervention programs. Though these proposed innovations are bold, incremental policy actions over the next several years can guide a shift from a criminal-legal to a public health approach. This shift supports an enhanced collective understanding of IPV as the product of complex societal, community, and individual factors as well as the identification and implementation of dynamic solutions at each of these levels. Through this shift, California can uplift healing, strengthen communities, and move the needle towards realizing transformative justice.

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