



California State Association of Counties



Support Hub for Criminal Justice Programming

*Pathways To Change:
Incorporating Behavioral
Health Responses to Reduce
Intimate Partner Violence*

Support Hub Vision

A California criminal justice system that is data-driven and evidence-based, allowing policymakers and practitioners to draw on data and research to improve outcomes, cost-effectiveness, and equity.



***Lead Project Consultant:
Kevin O'Connell***

CONTENTS

Introduction.....	2
Criminal Justice Responses to Intimate partner violence (IPV).....	7
Pathways to Services	9
Addressing the Risk Factors.....	11
Addressing Needs	12
Responsivity and Program Tailoring	14
Current Intimate partner violence (IPV) treatment Models	15
Current Funding and how to create a Blended STRATEGY	18
Next Steps.....	20

INTRODUCTION

The causes of intimate partner violence (IPV) are complex and diverse, and the solution is more complicated than just treatment, incarceration, or prevention. The blending of public health and primary prevention is an essential upstream contribution for reducing first-time and repeat victimization. One of the most common risk factors of IPV is unmet behavioral health needs, especially substance use. Studies have indicated that substance use is present in over half of people that perpetrate IPV. Nationally, there is a growing interest in rethinking the responses and treatment approaches for those convicted of IPV. This paper lays out options for integrating the sometimes-divergent public safety and treatment demands and provides potential pathways for funding IPV treatment programs.

Intimate partner violence is a particular type of domestic violence involving people in a romantic or dating relationship¹. It is essential to differentiate the prevalence of IPV from what is reported and prosecuted, which is challenging since IPV is often under-identified and under-reported. In addition, the context of violence and abuse is often engrained in numerous other behaviors and experiences. To truly end the cycle of IPV, there need to be flexible approaches that use all of the community's resources. Integrating behavioral health treatment into IPV interventions means purposefully intervening with those convicted of IPV with an approach that leverages probation case management, changing the batterer's attitudes, and addressing behavioral health needs. This intentionality comes from tailoring case management and treatment while increasing funding options to create sustainable and high-quality programming.

THE SURVIVOR'S SAFETY NEEDS TO BE FRONT AND CENTER IN CONSIDERING THE LIMITS OF BEHAVIORAL HEALTH TREATMENT AND BATTERER INTERVENTION PROGRAMS IN CHANGING BEHAVIOR.

The survivor's safety needs to be front and center to understand the limits of treatment in changing batterer behavior and how IPV treatment, behavioral health treatment, and probation supervision must work together. Most California Counties have a mandated 52-week Batterers Intervention Program (BIP) for those sentenced under 1203.097² for IPV crimes. However, six Counties are currently operating in a pilot program where the dosage and intensity of the IPV programming can vary with the individual's needs. AB 372³, which gives these pilot Counties

¹ Preventing Intimate Partner Violence | Violence Prevention | Injury Center | CDC. (2021). Retrieved 26 August 2021, from <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>

² CA Penal Code, Section 1203.097

³ Bill Text - AB-372 Domestic violence: probation. (2018) Retrieved 8 May 2021, from https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB_372

the ability to customize the court-mandated treatment for those convicted of IPV, allows Counties to align the risk of revictimization and offer other services to meet treatment needs.

While AB 372 offers pilot Counties the flexibility to tailor supervision for convicted individuals, Counties must further integrate behavioral health approaches to break down service barriers to effectively treat abusive behavior.

RISK NEED RESPONSIVITY

The current pilot of IPV programming under AB 372 gives Counties the ability to adjust services, and batterer intervention dosage using the principle of Risk Needs Responsivity (RNR).⁴ At its core, RNR is an evidence-based probation supervision strategy that focuses supervision resources at individuals most likely to recidivate; treatment that addresses the individual's dynamic needs (most likely to reduce recidivism); and addresses barriers such as mental health, housing, and English as a second language. This paradigm shift would allow substance use, unmet trauma needs, and mental health needs to be addressed before, or concurrently with, entering a batterer program. As a result, the person is more willing and prepared to engage in the programming offered. However, based on an initial analysis of client demography under AB 372 pilot counties, more attention needs to be paid to the diversity of people convicted of IPV in terms of their underlying needs, including those individuals' levels of risk for committing future IPV or other crimes. To that end, programs need to be thoughtfully built to provide individuals that commit IPV treatment plans that look to address multiple needs concurrently, with IPV reduction at its foundation.

Under the 52-week model – in place since the 1990s – people under probation supervision for IPV must navigate a mandated program and concurrently work to address their behavioral health treatment needs in parallel to the IPV program, where the two remain disconnected. This mandate, in effect, creates no straightforward way to sequence treatment in a manner that meets multiple complex needs. Although no all-inclusive list exists on the variety of batterer intervention programs available or in use, programs do not typically focus on underlying treatment needs in California. Instead, these programs focus on attitudes and behaviors that prompted the victimization of others and accepting accountability. Most IPV treatment programs in California are not clinical therapy, nor are they eligible for the significant behavioral health funding streams, limiting the approaches, and underlying therapeutic needs that can be addressed. This approach means that, even though an individual may receive nearly 100 hours of dosage for IPV, these approaches will not address issues beyond IPV. Additionally, these programs are nearly always funded by the individual convicted of the offense. The use of

⁴ O'Connell, K. and Wilson, M. (2021). AB 372 Dashboard and overview of clients available here: [https://public.tableau.com/profile/oconnellresearch#!/vizhome/AB 372ReportingDashboard/AB 372DataDashboard](https://public.tableau.com/profile/oconnellresearch#!/vizhome/AB%20372ReportingDashboard/AB%20372DataDashboard)

a sliding scale (i.e., lower income pays less) for treatment costs may assist people in making payments, but this impacts providers in what kind of treatment is offered. Therefore, California needs to look at long-term funding strategies in addition to new treatment modalities for individual case planning.

Modern correctional practices give some insight into how to best address the issues of re-offense, the risk to survivors, and meeting the individual's needs to reduce future recidivism and victimization. The six pilot Counties authorized under AB 372 are testing new service models, both in how people are supervised on probation and the types of IPV programs to which individuals are referred. This flexible framework also allows Counties to develop conjoint intervention models that address behavioral health needs together. Recent survey data shows Californian's support alternatives to jail or justice involvement that also meet complex human service needs.⁵

For low-risk clients, a human service intervention is ideal. With continued supervision by probation, the court, and meaningful treatment intervention, these probationers will be less likely to pose a threat to others; however, as an individual's risk level increases, the paradigm shifts. Thus, it is crucial to consider both risk and needs when implementing evidence-based interventions. AB 372 provides an opportunity to better target human service needs to those who may continue a pattern of violence while also increasing flexibility in the treatments offered to effectively disrupt patterns of violence.

TREATMENT NEEDS


Substance use and unmet mental health needs often interfere with the ability of a batterer to comply with their court-ordered treatment, both in attendance and engaging in behavior change. A 2009 study of California IPV showed that 40 percent of clients in BIPs had elevated levels of substance use, which was often an impediment to sustaining their attendance at the BIP.⁶ Recent surveys of Adverse Childhood Events (ACES) of batterers also showed significant levels of ACES, with 33 percent having experienced IPV as children.⁷ ACEs are an essential factor in looking at treatment needs because they summarize a range of traumatizing events in early

⁵ Survey Documents Uneven Impact of COVID-19 on California's Communities of Color. (2021). Retrieved 7 May 2021, from <https://blueshieldcafoundation.org/newsroom/press-releases/20210323/survey-documents-uneven-impact-covid-19-californias-communities>

⁶ MacLeod, D., Pi, R., Smith, D., & Rose-Goodwin, L. (2009). Batterer intervention systems in California: An evaluation. San Francisco: Judicial Council of California/Administrative Office of the Courts.

⁷ Mair, C., Cunradi, C., & Todd, M. (2012). Adverse childhood experiences and intimate partner violence: testing psychosocial mediational pathways among couples. *Annals Of Epidemiology*, 22(12), 832-839. doi: 10.1016/j.annepidem.2012.09.008.

childhood that can have a cumulative impact on an adult.⁸ This points to the ongoing need for treating youth who are either witnesses to or survivors of IPV, including acknowledging the often-untreated trauma in the current adult population. This information also means that batterers do not always have distinct needs or trauma and may need changes in thought patterns, which are better met through a range of interventions and treatment dosage. A series of connected interventions can address general issues like anti-social thought patterns, anti-social peers, and better support effective batterer intervention programs.



40 PERCENT OF PEOPLE THAT COMMIT IPV HAVE ELEVATED LEVELS OF SUBSTANCE USE AND 33 PERCENT EXPERIENCED IPV AS CHILDREN.

This dosage can be met through interactions with probation officers or treatment providers, but all need to work in concert to change behavior. The number of hours of dosage from all sources should increase with the level of risk.⁹ AB 372 pilot counties can fully explore these case management and interaction strategies based on risk to re-offend, the risk for future IPV, and results from validated assessment tools. AB 372 counties each develop local decision-making matrices that correlate risk of recidivism and risk of future IPV to determine the dosage of batter intervention programs and the corresponding interventions as shown by a needs assessment.

Looking at other drivers of IPV does not absolve people of their actions or give tacit permission. Still, it acknowledges that interventions need to be targeted and specific to individuals to change behavior. Further, the correlation of substance use, unmet mental health needs, and IPV behavior point to using sentenced interventions in more creative and dynamic ways. Addressing behavioral health needs is just one aspect of ending the cycle of IPV, but its key component is not effectively integrated with the current IPV mandates and treatment delivery systems. Without a more effective integration of behavioral health services and direct funding, a gap continues when treating people who commit and continue IPV.

Specific types of abuse can distinguish perpetrators of IPV: some are verbally manipulative and isolating, others are financially controlling, others are violent, and many have a combination of the above. Human service needs are only one set of dynamics, and research on the risk factors

⁸ “ACEs” is an acronym for Adverse Childhood Experiences. They refer to adversity children faced in the home environment—various forms of physical and emotional abuse, neglect, and household dysfunction.

⁹ Carter, M., & Sankovitz, R. J. (2014). Dosage probation: Rethinking the structure of probation sentences. Silver Spring, MD: Center for Effective Public Policy.

of IPV tends to show multiple complex relationships and interactions.¹⁰ Recent data reporting from AB 372 pilot counties show that nearly 60 percent of offenders are high or medium risk to re-offend, with 40 percent at low risk. Understanding these risk levels creates an opportunity to better tailor services, inter-agency support, and most importantly, levels of supervision in the community to enhance survivor safety and change batterer behavior.

ACTIONS

- Look for ways to give probation and the courts more options to meet multiple needs through changing current legislation around Penal Code, Section 1203.097, as the motivations and risk factors for IPV are complex.
- Create a framework for IPV diversion that focuses dosage on a treatment program that matches specific offender circumstances, which could be especially effective for low-risk offenders with low levels of risk for repeat victimization.
- Create a court-based fund for alternative Batterer Intervention Programs for individuals convicted of IPV. This fund could reduce the financial strain on participants mandated to treatment for IPV, in addition to boosting the programming options available from providers.
- Develop best practices around court case management to improve court-related coordination around programming compliance through specialized IPV court calendars. This work could include handling arraignments, status hearings, and violations of restraining orders. Additionally, this coordination could help develop alternative responses and better align interventions and services and keep the survivor's voice throughout the process.
- Refine probation assessment pathways that connect people with behavioral health needs, whether primary care for mild-moderate cases or Medical for those uninsured. By building on existing partnerships between probation and behavioral health, screening and assessment can connect people to treatment sooner.
- Fund pilot programs that meet IPV needs in non-traditional ways, like integrating IPV treatment into substance use treatment, trauma-informed Cognitive Behavioral Treatment, and other wraparound programs that offer case management and service referrals.
- Expand AB 372 to Counties ready and willing to look at more deliberative ways to address IPV, including a documented plan and partnership agreements with service providers.

¹⁰ Capaldi DM, Knoble NB, Shortt JW, Kim HK. A Systematic Review of Risk Factors for Intimate Partner Violence. *Partner Abuse*. 2012;3(2):231-280. doi:10.1891/1946-6560.3.2.231

- Create a state-level inventory of IPV-related programs and curricula that show promising practices or are evidence-based to meet IPV reduction goals and small-scale behavioral health needs. This inventory can give Counties choices as to curriculum and centralize knowledge around program implementation and fidelity. The appropriate state or county leadership organization can then disseminate best practices, engagement, and learning. Other states have started similar efforts and could be a model for better coordination and collaboration to enhance local expertise.

CRIMINAL JUSTICE RESPONSES TO INTIMATE PARTNER VIOLENCE (IPV)

More than 160,000 IPV-related calls for service are made to police every year in California, where 45 percent of incidents involve weapons.^{11,12} Further, statewide calls for service data fail to capture the true volume of IPV in our communities since not all survivors feel safe enough to report crimes. Abuse can also

take the shape of interpersonal manipulation that may not generate a call to law enforcement. Some of these calls for service result in the arrest, prosecution, filing of protective orders, and court-mandated treatment for those found guilty of committing acts of IPV. To change behavior for those convicted of IPV on an intimate partner, the intervention model needs to draw on multiple areas of behavior change, substance use, mental health intervention, court-ordered supervision in the community, and supportive services.

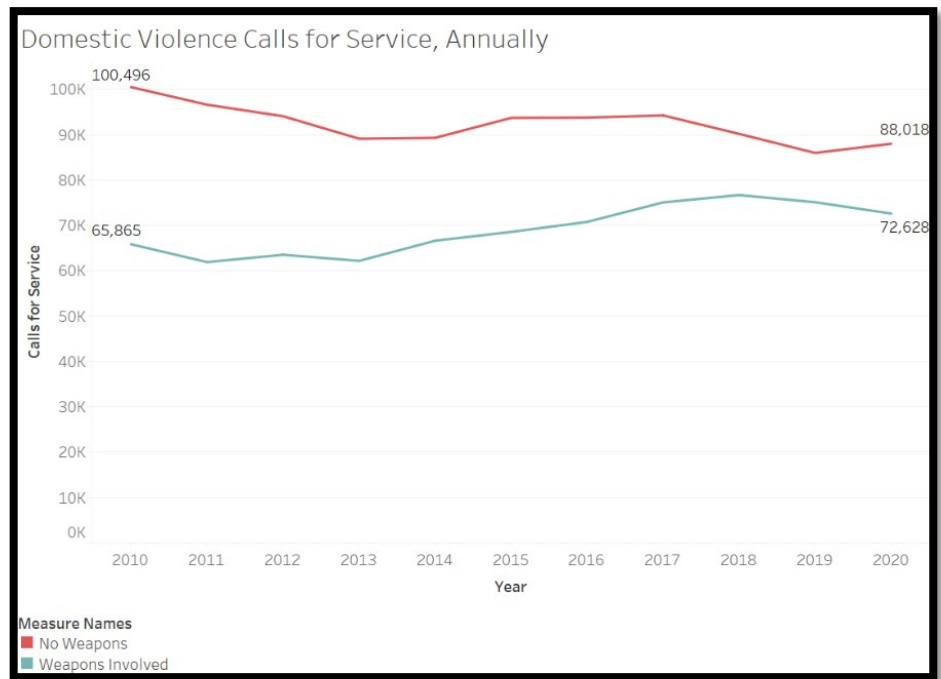


Figure 1: California Domestic Violence Calls for Service

¹¹ Domestic Violence Calls for Service, <https://openjustice.doj.ca.gov/data>

¹² Domestic violence is defined as “...abuse committed against an adult or a minor who is a spouse, former spouse, cohabitant, former cohabitant, or person with whom the suspect has had a child or is having or has had a dating or engagement relationship.” [13700(b) PC] Abuse is defined as “...intentionally or recklessly causing or attempting to cause bodily injury, or placing another person in reasonable apprehension of imminent serious bodily injury to himself or herself, or another.” [13700(a) PC]

For people convicted of intimate partner violence crimes, there are not many holistic therapeutic options. For that, the State should move to more integrated care that truly wraps services, supports, and public safety around survivors by thinking differently about people who commit IPV. This starts with acknowledging that motivations and solutions to IPV are not singular, as the research on IPV is nuanced as to specific diagnosis and risk profiles. State leaders should consider options to give Counties more resources and flexibility around how IPV services are delivered to clients and raise the bar on treatment funding and expectations of using evidence-informed practices. California can be a national leader in supportive and responsive services instead of perpetuating the inefficient and ineffective one-size-fits-all approach. While there already exists a level of discretion within the system, more thoughtful and nuanced approaches can help identify ways to connect people to resources to help survivors and directly address IPV behavior. Figure 2 shows a typical case flow, illustrating how an IPV incident moves through the justice system and convicted under Penal Code (PC), Section §1203.097.



Figure 2: IPV Response Process Flow

People sentenced under PC §1203.097 must attend a batterers intervention program, but what qualifies as an intervention can vary widely. There need to be more clear options available to Counties in how to fund and intervene with people in customized ways.

Changing attitudes and holding people accountable should still be fundamental aspects of an IPV response, but they should not be the only goals. Research has shown that the risk of re-offense and repeat intimate partner violence should determine the amount of treatment dosage a person receives. Although the statute identifies the amount of time someone is court-mandated to attend a BIP, it is silent on the multitude of other things that may also contribute to ending the cycle of IPV. Most people sentenced for IPV offenses under PC §1203.097 could be served better under a mix of program referrals and interventions, in addition to a BIP. However, the mandate of 52 weeks often complicates entrance into employment programs, substance use treatment, and even mental health needs assessments.

Behavioral health interventions for those convicted of IPV need to be integrated into the treatment model for IPV and be funded at a level that can genuinely wrap services and interventions around people. Studies of people who commit IPV paint a varied picture, with factors such as alcohol abuse, mild-to-moderate mental health diagnosis, unmet treatment around trauma, and borderline personality disorders combining with other destabilizers, forming an intricate web of needs. What is truly needed is an integrated model that matches survivor safety with multiple types of batterer treatment delivered at the right time and in the right amount.

This integrated, wraparound model does not currently exist in California, partly because the 52-week IPV treatment mandate demands a specific type and amount of treatment for all offenders. To change the paradigm for those convicted of IPV, there needs to be an approach that gives courts and probation a full array of responses to address the drivers of intimate partner violence and differentiate between individuals at risk of repeating the behavior and those less likely to do so. This differentiation can match the many resources and interventions available with the spectrum of individual needs of those who commit IPV to effect behavior change.

PATHWAYS TO SERVICES

When offered as an intervention after an IPV incident, behavioral health treatment alone assumes that all the negative impacts of IPV could be avoided if the batterer only had access to treatment or preventative interventions. Therefore, it is essential to differentiate a prevention strategy from an intervention strategy, especially when a survivor is involved. The stakes for adult and child survivors of IPV can't be understated, as even with a growing body of research

on how to help with psychological recovery, the family systems often remain broken or complicated by batterers who are still part of their survivor's lives.¹³ Macleod et al.'s (2009) study of California BIPs showed that 40 percent of batterers still live with their survivor, with 33 percent living with children. Although survivors can be of any gender and relationship type, recent data within AB 372 pilot counties shows that nearly 90 percent of batterers are men.¹⁴ A more cohesive approach includes merging several areas of evidence concerning changing attitudes around IPV by batterers and behavioral health delivery into a strategy that could be a promising addition to the field.¹⁵ The AB 372 pilots are currently developing new IPV programming treatment models and approaches for case planning and sequencing other interventions.

Debra Gehring, Senior Probation Officer,
Napa County

“YOU CAN’T JUST LOOK AT A BATTERER’S SUBSTANCE USE OR MENTAL HEALTH ALONE, YOU HAVE TO ALSO LOOK AT WHAT ELSE IS GOING TO CHANGE THEIR UNDERLYING RISK TO REVICTIMIZE.”

Changing perceptions of the roles and consequences of stressors is a key step in aligning public health approaches with IPV interventions. Secondary prevention that targets community and shared resources on people at risk of further IPV who experience housing or economic stress can also be important. As a preventive approach, there can be a range of human service interventions to prevent stressors, increase community supports, and address unmet treatment needs before these turn into violent situations. When someone is being victimized, either physically or verbally, risks and strategies must be taken to change batterer behavior and ensure survivor safety.

Although much research has been done to separate people who batter and those that do not, batter typologies are diverse. The main typologies seen in the empirical analysis are¹⁶:

¹³ Anderson, K., & van Ee, E. (2018). Mothers and Children Exposed to Intimate Partner Violence: A Review of Treatment Interventions. *International journal of environmental research and public health*, 15(9), 1955. <https://doi.org/10.3390/ijerph15091955>

¹⁴ O’Connell, K. and Wilson, M. (2021). AB 372 Legislative Report: Year 1-Applying Evidence Based Practices to Batterers Intervention Programs. Retrieved from https://www.counties.org/sites/main/files/file-attachments/AB_372_year_1_legislative_report__final.pdf

¹⁵ Radatz DL, Wright EM. Integrating the Principles of Effective Intervention into Batterer Intervention Programming: The Case for Moving Toward More Evidence-Based Programming. *Trauma, Violence, & Abuse*. 2016;17(1):72-87. doi:10.1177/1524838014566695

¹⁶ Huss, M. T., & Ralston, A. (2008). Do batterer subtypes actually matter? Treatment completion, treatment response, and recidivism across a batterer typology. *Criminal Justice and Behavior*, 35, 710-724. doi:10.1177/0093854808316218

- Generally violent/anti-social: batterers who have shown to be assaultive with high levels of both marital and generalized violence and show overall criminal tendencies
- Borderline/dysphoric: high levels of anger and depression, moderate levels of substance use, and personality disorders.
- Family-only batterers: exhibit lower rates of alcohol abuse, depression, and personality disorders, as well as pro-social personality traits.

These typologies are not meant to limit treatment options but to show the diversity of batterers.

There is a large body of research on the critical factors associated with the future risk of recidivism. These are often divided into the risk factors that change over time (dynamic) and those that do not (static).¹⁷ These, in conjunction with factors such as employment, education, substance use, and familial factors, are used to target types of interventions and the dosage of the intervention.

ADDRESSING THE RISK FACTORS

There are also specialized tools for measuring the risk of future IPV or interpersonal violence, which are included in crafting supervision case plans to best reduce future acts of IPV and ensure successful outcomes for the probationer. In the case of IPV, the goals are to minimize revictimization of the same person and change patterns in the batterer to reduce future victims in general.

When used together, risk assessments that consider multiple areas of need, especially the risk of interpersonal violence, can provide positive steps in getting more nuanced referrals and targeting resources. This assessment level information creates opportunities to tailor approaches that consider the risk of re-offending to most effectively reduce future victimization. California's decentralized probation system means there is no single statewide approach, mainly due to implementation issues and local program availability. On the other hand, Colorado implemented a risk-needs responsive model for IPV in 2010 to help navigate local implantation issues and variability. They saw improvement in treatment completion when the client's risk and needs were considered in determining the intensity and approach of the intervention.¹⁸ This is a model for California to consider moving forward.

¹⁷ Bonta, J. and D.A. Andrews (2007). Risk-Need Responsivity Model for Offender Assessment and Rehabilitation. Ottawa: Public Safety Canada.

¹⁸ Richards, Tara & Gover, Angela & Tomsich, Elizabeth. (2015). Colorado's Innovative Response To Domestic Violence Offender Treatment: Current Achievements And Recommendations For The Future.

When addressing risk for future IPV, probation departments should look at the general risk of re-offending and the threat of future intimate partner violence.

DV Risk	General Risk to Reoffend		
	Low	Medium	High
Low	47%	11%	2%
Medium	15%	1%	5%
High	6%	6%	8%

Figure 3: Risk Assessment Scores. County "X."

Both can be estimated via validated assessment tools. Though measured differently, they are instructive when looking at the interventions most likely to change behavior. For example, for someone with a lower risk of future IPV but higher risk of recidivism, case planning and treatment might focus more on a distinct set of needs or interventions. Conversely, someone at higher risk of IPV would need to have maximum treatment dosage to change thought patterns around IPV.

In figure 3 above, from County "X," the aggregate risk assessment scores show how using both scores together can help target resources. The analysis shows that 47 percent of IPV clients were low risk to re-offend and low risk of IPV. Conversely, only 8 percent were at high risk to re-offend and commit another act of IPV. AB 372 pilot counties can leverage this difference to appropriately case plan and direct resources in targeted ways that align risk with needs (i.e., the risk-needs responsivity factor).

ADDRESSING NEEDS

Intimate partner violence is a complex social problem and having a singular dosage mandate of 52-weeks for BIPs removes or delays interventions that would also address revictimization.

Looking at the needs of those that are low risk to re-offend points, if addressed effectively, can work in conjunction with IPV programs. Depending on the level of risk, counties can consider

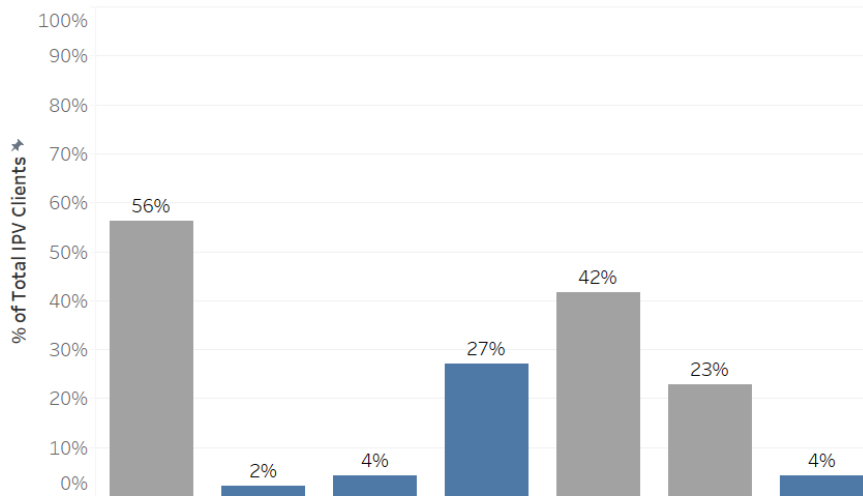


Figure 4: Assessed Needs of Low Risk IPV Clients (County X)

the likelihood of re-offense and the best treatment path. Figure 4 illustrates how a range of interventions could be defined to address the unique needs of low-risk offenders. For example, this data shows that 56 percent of low-risk offenders need approaches that address substance use, while 42

percent need employment assistance. Additionally, it shows low-risk clients have low areas of need around criminal attitudes and anti-social peers, which highly predict future recidivism.

Ultimately, this information further points to an approach that addresses IPV but assumes low-risk clients need connections and services rather than higher intervention and treatment dosage levels. Furthermore, developing specific treatment methods for low-risk individuals can also avoid mixing low and high-risk populations, which can be detrimental to low-risk individuals engaged in an intervention.¹⁹

Figure 3 above outlines that IPV clients at high risk of future recidivism made up 15 percent of the IPV clients, and their needs were increasing more complex. As a group, the interventions most likely to change future justice involvement for high-risk populations included alcohol/drug treatment, education, familial needs, and thinking patterns, attitudes, and peers. Ultimately, the treatment dosage goes far beyond just addressing patterns of IPV and requires a range of interventions.

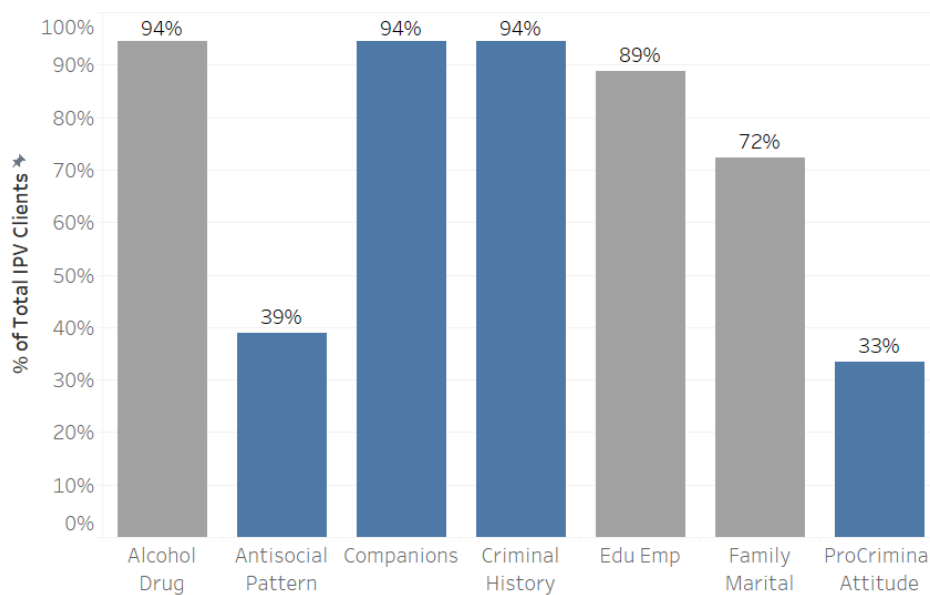


Figure 5: Assessed Needs of High-Risk IPV Clients (County X)

Using dynamic risk factors can help direct services to those with the most pressing needs, especially substance use and unmet mental health needs. Contemporaneous levels of substance use are highly correlated with IPV and an elevated risk factor in the future.²⁰ Factors

¹⁹ Lowenkamp, C. T., Latessa, E. J., & Holsinger, A. M. (2006). The Risk Principle in Action: What Have We Learned From 13,676 Offenders and 97 Correctional Programs? *Crime & Delinquency*, 52(1), 77–93. <https://doi.org/10.1177/0011128705281747>

²⁰ Jones, A., & Gondolf, E. (2001). *Journal Of Family Violence*, 16(4), 345-359. doi: 10.1023/a:1012268725273

like mental illness are seen as a responsivity issue, such that mental illness alone is often not the cause of future criminal behavior. However, it often precludes treatment engagement and happens alongside substance use.²¹ For batterers, this means that the behavioral health factors that cause IPV are more likely related to substance use, but mental illness gets in the way of treatment. To this end, new targeted opportunities to merge the dosage of probation interventions, IPV curriculum, and behavioral health needs can offer new options. Counties need the flexibility to choose the most effective programming tool to change behavior by meeting dynamic needs or providing effective IPV programming.

Integrating interventions for perpetrators of IPV should be part of a more extensive coordinated network of criminal justice responses and community services to hold batterers accountable for stopping violent and threatening behavior. The role of co-occurring disorders and unmet treatment needs underscores the need to address multiple complex needs concurrently. The challenge in doing this starts with the divergent philosophies about "what works" to interrupt patterns of IPV and the distinct treatment needs of individual batterers.

RESPONSIVITY AND PROGRAM TAILORING

Matching the right programs at the right time plays a vital role in changing behavior for people convicted of IPV. Even with assessments helping to target the highest priority needs, the effectiveness of those interventions is particular to an individual. The ideas of general and specific responsivity posit that IPV interventions themselves need to be highly effective, including being targeted to characteristics of the person.²²

General responsivity points to the kinds of programming effective at changing behavior and how people convicted of IPV engage with probation and program staff. In and of itself, the dosage of probation, treatment needs, and IPV programming needs to be cohesive.

Specific responsivity covers a range of issues, each with its own research base. The overarching idea is that changing behavior needs to acknowledge and engage people and enhance their motivation to change. Responsivity issues are usually seen as not contributing to or predictive of further justice involvement but are a barrier to effective treatment. Examples include, but are not limited to:

- Gender

²¹ Skeem, J. L., Manchak, S., & Peterson, J. K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior, 35*(2), 110–126. <https://doi.org/10.1007/s10979-010-9223-7>

²² Andrews, D. A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). New Providence, NJ: LexisNexis Matthew Bender.

- Ethnicity, Language, and Cultural Attributes
- Serious Mental Illness

These concepts move the conversation away from IPV programming as the sole contributor to change and reinforce the need for integrated programs that are more adaptive.

CURRENT INTIMATE PARTNER VIOLENCE (IPV) TREATMENT MODELS

Most batterer intervention programs in California, regardless of programming approach, are not clinical and usually administered through group sessions and counseling. These programs are delivered through curriculum guides or general counseling sessions.

They fall into two broad approaches:

- Psycho-educational/Duluth model: This approach tries to educate batterers about the power and control dynamics and does not focus on psychological aspects of their crimes. Further, it focuses primarily on men, so it often lacks a clear connection to women or same-gender couples.
- Cognitive-behavioral: This approach attempts to change thought patterns, and current CBT focuses on responsibility for abusiveness, assertiveness, and awareness of anger.

Further complicating things, some mixed models use elements of CBT as well as Duluth models. This hybrid approach makes clearly defining the most effective model difficult and is reinforced by disagreements about the best strategies in the field of IPV.²³ There is a need to allow probation and clients ways to navigate mandated treatment and better identify referral pathways for people where higher levels of clinical care could augment any IPV curriculum.

Several treatable components of intimate abusiveness are not addressed by current cognitive-behavioral treatment (CBT) models or psychoeducational approaches: attachment anxiety, borderline personality traits, substance abuse, and trauma reactions. This gap in treatment is essential in developing new strategies that can effectively reduce intimate partner violence and meet treatment needs²⁴. However, the lack of a clear treatment pathway means evidence is still needed to fully understand the most effective and practical strategies. Under PC §1203.097, Counties can develop treatment plans but often lack good choices when certifying providers to offer options to batterers.

²³ Miller, M., Drake, E., & Nafziger, M. (2013). What works to reduce recidivism by domestic violence offenders? (Document No. 13-01-1201). Olympia: Washington State Institute for Public Policy.

²⁴ Dutton, D. G. (2008). Blended behavior therapy for intimate violence. *Intimate partner violence prevention and intervention: The risk assessment and management approach*, 133-146.

The exact type of BIPs or treatment may also be less important than the personal factors. Criminology and the study of IPV have found a population of low-risk offenders who may have a high amount of justice involvement but subsequently reduce their battering acts quickly.²⁵ This behavior change comes from the theory that lower-risk offenders who have a "stake in conformity" and value a return to normality will often feel levels of shame that move them to make improvements.²⁶ MacLeod et al. (2009) found that individual characteristics were the strongest predictor of rearrest in their study of California BIPs. Men who were more educated, older, had shorter criminal histories and did not display signs of drug or alcohol dependence had a lower likelihood of rearrest, independent of the kind of treatment they received.

This research brings the discussion back to how best to address behavioral needs and treat IPV effectively. It is essential to consider that mental health needs by themselves have not been shown to cause or predict IPV alone. Still, the role of emotional regulation may have implications for further screening and assessment.²⁷ The same is not true for substance use, where studies found a strong relationship between substance use – specifically alcohol – and IPV.²⁸ The critical component is to ensure screening and referral, especially for clients that may appear to be low risk to re-offend. Programs should be developed to group low-risk offenders together and not mix them with higher-risk offenders.

Sarah Fletcher, Adult Division Director Santa Cruz County
Probation County

“OUR STRATEGIES NEED TO BE INTEGRATED, WHERE PROBATION SUPERVISION, DOMESTIC VIOLENCE PROGRAMMING, AND BEHAVIORAL HEALTH NEEDS ARE ADDRESSED SIMULTANEOUSLY.”

If an evidence-based substance use disorder program can reduce abuse, it is reasonable to think this would reduce IPV when the need is related to substance use. However, suppose substance use disorder or co-occurring disorders are a barrier to attending BIP programs. In that case, presently, only the six pilot Counties currently have the flexibility to adjust treatment plans or the timing of the interventions. Further, innovative programs could incorporate

²⁵ Maxwell, C.D., J.H. Garner, and J.A. Fagan (2001). *The Effects of Arrest on Intimate Partner Violence: New Evidence from the Spousal Assault Replication Program*, Washington, DC: National Institute of Justice.

²⁶ Wooldredge, J., Thistlethwaite, A. Reconsidering Domestic Violence Recidivism: Conditioned Effects of Legal Controls by Individual and Aggregate Levels of Stake in Conformity. *Journal of Quantitative Criminology* 18, 45–70 (2002). <https://doi.org/10.1023/A:1013292812895>

²⁷ Watkins, L. E., Schumacher, J. A., & Coffey, S. F. (2016). A preliminary investigation of the relationship between emotion dysregulation and partner violence perpetration among individuals with PTSD and alcohol dependence. *Journal of Aggression, Maltreatment & Trauma*, 25, 305-314. doi:10.1080/10926771.2015.1129657

²⁸ Cafferky, B. M., Mendez, M., Anderson, J. R., & Stith, S. M. (2016). Substance use and intimate partner violence: A meta-analytic review. *Psychology of Violence*, 1-22. Advance online publication. doi:10.1037/vio0000074

substance use disorder programming elements into IPV treatment through brief interventions or a further specialized curriculum to meet batterers' tailored substance use disorder needs. This approach, called conjoint treatment, has shown some promise in improved outcomes where alcohol was treated in brief interventions, alongside batterer intervention programs.²⁹

Another program that has shown promise in reducing aggression and treatment needs is Acceptance Commitment Therapy³⁰. Acceptance and Commitment Therapy (ACT) aims to increase psychological flexibility and decrease experiential avoidance through talk therapy. Psychological flexibility is the ability to do what is important, even if psychological barriers (e.g., anger, fear, shame) are present. Experiential avoidance occurs when a person is unwilling or unable to deal with specific internal experiences (e.g., emotions, thoughts, urges) and instead engages in the behavior to alter the form or frequency of those inner experiences, even when doing so may cause harm to self or others.

As California pilots a risk-based approach to IPV treatment in six Counties, alongside a new, more flexible program offering, it is vital to identify what works and how it will be sustained. As discussed above, IPV programs do not have a direct funding source. This concept is partly due to political sensitivity that batterers should pay for their crime to have "skin in the game." Further, most programs lack a consistent curriculum and are not designed to address critical areas of behavioral health. Additionally, the offender-pay model limits the extent of money providers receive and creates a challenge for the batterer or their family, given the nearly 50 percent unemployment rate in AB 372 pilot Counties.³¹

As Counties work to align IPV treatment and service dosage, it is crucial to continue to look at interventions and systems beyond the IPV treatment curriculum and create blended funding and dosage. For example, models that combine the time on supervision and probation contacts with dosage delivered through referrals may be a promising concept. Still, more research is needed on what dosage counts and the relationship between efficacy and dosage.³² This experiment is already underway with AB 372 Counties, as they experiment with different amounts of IPV programming dosage and other types of services based on risk to re-offend.

²⁹ Wilson, I. M., Graham, K., & Taft, A. (2014). Alcohol interventions, alcohol policy and intimate partner violence: A systematic review. *BMC Public Health*, 14, 1-11. doi:10.1186/1471-2458-14-881

³⁰ Zarling, Amie, Erika Lawrence, and James Marchman. "A Randomized Controlled Trial of Acceptance and Commitment Therapy for Aggressive Behavior." *Journal of Consulting and Clinical Psychology* 83(1):199–212.

³¹ O'Connell, K. and Wilson, M. (2021).

³² Kroner, D. G., & Takahashi, M. (2012). Every session counts: The differential impact of previous programs and current program dosage on offender recidivism. *Legal and Criminological Psychology*, 17(1), 136–150. <https://doi.org/10.1111/j.2044-8333.2010.02001.x>

CURRENT FUNDING AND HOW TO CREATE A BLENDED STRATEGY

The offender-pay model is the primary source of funding for IPV programming, making it challenging to provide the continuum of services that offenders need, due to the low ability to pay. Therefore, new, and sustained funding sources are required to make the improvements discussed above to reduce recidivism and victimization.

Some Counties have begun to augment these programs from Realignment Fund sources derived from legislation like AB 109³³ and SB 678³⁴. Still each County provides a list of programs based on those certified under PC §1203.097 as meeting the requirement for IPV treatment, and each provider handles the payment and compliance of the batterer. This structure means that batterers pay for the service on a sliding scale³⁵ based on their ability to pay, and from that payment, providers construct their business model. The innovation for IPV programming would offer a creative way to increase the level of service to meet behavioral health needs, including designing programs to access multiple funding streams. There would be a valuable new contribution by developing programs that reduce future victimization through accountability and education while addressing behavioral health needs. It is important to create a system where batterers who are legally able to access these services can do so, regardless of their IPV programming. The current system often lacks the integration and tailoring that many batterers need. Below are several possible funding stream collaborations that could offer valuable services and create pathways to new services.

- *Substance Use Disorder (SUD) Organized Delivery System (ODS)* ³⁶- Fund Brief Interventions to engage batterers in their substance use needs and create a pathway to deeper treatment engagement. This funding could also be used for assessments or other service engagement, depending on the level of need. By focusing early on assessment and identification, appropriate service can then be brokered to fit with the level of need and insurance status. This funding stream would not fund IPV treatment

³³ Bill Text - AB-109 Criminal justice alignment. (2011). Retrieved 18 November 2021, from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB109

³⁴ Bill Text - SB-678 Criminal recidivism. (2009). Retrieved 18 November 2021, from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=200920100SB678

³⁵ PC1203.097 defines a sliding fee schedule as one that recognizes both the defendant's ability to pay and the necessity of programs to meet overhead expenses. An indigent defendant may negotiate a deferred payment schedule, but shall pay a nominal fee, if the defendant has the ability to pay the nominal fee.

³⁶ Drug Medi-Cal Organized Delivery System Overview . (2021). Retrieved 11 May 2021, from <https://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>

alone but could provide services for case management or coordination for more clinical positions like licensed social workers.

- Mental Health Services Act (MHSA)³⁷ - These funds cover a range of mental health care and are specifically designed to serve individuals with, and at risk of, serious mental health issues and their families. MHSA addresses a broad continuum of prevention, early intervention, and service needs for those with mental health needs. In addition, MHSA funds have been used to address the specific needs of IPV survivors. Still, the usual interpretation is that batterers, unless they are, or are at risk of serious mental illness, are not eligible for this funding.³⁸ However, Innovation (INN) funds could help create integrated programs and promote interagency collaboration, increasing quality and access to services.

Innovation projects have the most promise since they allow Counties to initiate, support, and expand partnerships. This is especially true for connections

between systems, organizations, and other practitioners not traditionally defined as a part of mental health care but are not long-term sustained funding sources. Regardless, counties would need to develop county-specific proposals to meet their local needs and community engagement processes. Further, innovation is necessary for reducing the intergenerational harm imposed by IPV.

Holly Child, Director of Research, Santa Clara County Probation

“FOR JUSTICE AGENCIES, NAVIGATING THE BEHAVIORAL HEALTH FUNDING STREAMS IS SOMETIMES UNFAMILIAR, AND COMPLEX, MAKING IT HARD TO FILL GAPS IN INNOVATIVE WAYS.”

There is also a need for developing a larger-scale demonstration project with the six AB 372 pilot Counties and other interested counties to create a more integrated IPV treatment program that aligns supervision, IPV treatment, and behavioral health treatment. This could lead to a more transformative change in how the criminal legal system intervenes with people that commit IPV. This model should be based on an offender's risk and needs and the survivor's supportive needs. Using this approach, a County could create customized case plans for higher-risk offenders and treatment and look at new modalities to meet the risk factors of IPV. The AB

³⁷ Mental Health Services Act (MHSA) Overview . (2021). Retrieved 11 May 2021, from https://www.dhcs.ca.gov/services/MH/Pages/MH_Prop63.aspx

³⁸ Survivors of IPV are often supported through MHSA funds through the Prevention and Early Intervention component. PEI is not available to batterers since they are not the ones at risk of SMI, but a case could be made that there is a need to address intergenerational harm. MHSA funds generally fall into services that prevent further decompensation or risk of mental illness (PEI) and community services that respond to those who have a serious mental illness (CSS).A list of MHSA investments for domestic violence can be found here: <http://transparency.mhsoac.ca.gov/searchpage>

372 pilot counties already have a model that supports this, but new counties could add a larger population base generating more research to continue innovation. In addition, more time or areas of exploration could expand the learning, testing, and incubation of "what works" that has started with AB 372.

Investing funds into rethinking the program offerings would be in partnership with local providers and agencies. AB 372 changed the court mandate but did not provide the necessary support to meet the programming needs, which means that further reform efforts should also be tied to more innovative incentive-based funding models. Assuming nearly half of the approximately 1,000 AB 372 pilot program participants are at elevated risk to re-offend; a more innovative approach could help to answer the following key questions:

- What kind of treatments work best together to treat both IPV attitudes as well as substance use issues?
- How can issues of unaddressed trauma be addressed differently, giving the batterer a sense of the harm, they have caused as a pathway to deal with their problems?
- Are there ways to address mild-moderate mental health needs more effectively in the context of IPV treatment?
- How do we develop programming models for the more complex relationships between batterer and survivor? Many paradigms are built on male spousal abuse of their wives. Programs must address other relationships dynamics as well.
- How do we create culturally responsive programming to address the underlying issues of IPV in linguistically and culturally relevant ways?

The complexity in developing these programs lies in what needs are being targeted and defining success. Through the support of the Blue Shield of California Foundation, several Counties will be creating an integrated curriculum addressing common criminogenic patterns, covering substance use and employment with IPV reduction at its core. Although the IPV curriculum can stand on its own, the integrated nature of IPV demands a holistic approach, increasing the likelihood of success for those who have committed acts of intimate partner violence.

NEXT STEPS

This brief blends learnings from the AB 372 pilot, along with the available evidence on the impact of treatment on reducing recidivism and revictimization among batterers. The current offerings that are based on cognitive-behavioral treatment and psychoeducation have shown mixed results. Numerous new modalities are being offered, but much of the research is too new to replace these models confidently. Several studies have shown that the underlying behavior that drives IPV is varied and that different therapy models have different effectiveness when treating various types of batterers. Further exploration of the risk principle shows that

lower-risk batterers would likely do the same in treatment regardless of the actual IPV treatment type due to responsivity factors around mental health needs. All of this suggests individualized treatment is needed for emerging mental health needs or substance use, in addition to tailored case planning by risk level. These factors, taken together, create a strong network when engaging in treatment.

Overall, this information points to coordinated responses from justice agencies with treatment providers and advocates to minimize the impacts on survivors. AB 372 pilot Counties have utilized best practices for general offenders by using risk assessments to tailor treatment plans and dosage into IPV treatment. This change will allow some Counties to examine if using a risk-based treatment for IPV improves outputs and outcomes. Since more research is needed to assess the efficacy of IPV treatment itself, it is critical to look at how programs are funded and designed in California. The State can help by adopting more explicit standards for model programs with help from programming and curricula experts in the field while giving Counties the ability to meet treatment needs in tailored ways.

A primary goal of the AB 372 pilot next should be to learn what works, for whom, and to support Counties in offering tailored strategies but still developing standards of the impact that are based on evidence. Relying more on assessment of needs and the provision of services that coincides with the level of risk will allow Counties to prioritize services that can change behavior, better ensure survivor safety, and end the cycle of IPV.