



the center

for violence-free relationships

education | advocacy | services

The Center for Violence-Free Relationships (The Center)

Founded in 1979 and located in Placerville, The Center provides a wide range of crisis intervention and prevention services for every individual whose life is impacted by intimate partner violence.

The Center utilizes a whole family approach and provides services to both adult and child victims of intimate partner violence (IPV) and sexual assault as well as intervention/prevention services to people who do harm (aka batterer's). **The Center is a performance and data driven organization and is at the forefront of introducing and moving domestic violence service providers to utilize data more robustly and focus on measuring the impact each program and service is having rather than merely counting the units of service delivered.**

The Center and its private partners invest in the research and development of programs designed to address the root causes of IPV. **The Center has created and piloted programs which are demonstrating positive impact related to prevention.** The whole family approach has been recognized at the local, state, national and international level for its innovative and ground breaking programs.

The Center employs 23 individuals and has an operating budget of \$2.1 million. The revenue breakdown is as follows; 57% Government, 26% Private Donations, 12% program specific grants and 5% Batterer Intervention program fees.

The Center provides victim services on average to 1200 clients annually. Additionally The Center provides services to 200 people who do harm. The Center's school based prevention program follows a school "saturation" model and provides 1,260 hours of healthy relationship curriculum to 580 middle school aged students delivered in twenty eight- forty five minute sessions.

Lastly, **in 2014 The Center built a state wide network of domestic violence service providers though the use of a shared data base.** The network was developed to help the service organization increase their evaluative capacity, share tools and utilizing client assessment aggregate data reports learn more about how to structure organizations, design and deliver services to clients in order to pivot from intervention to preventing recurrences of IPV.

Importance of Using Data

Historically CAL OES and other grantors require grantees to include “outcomes” data in their grant reports. Almost without exception grantors define “outcomes” as numbers of services provided and/or number of people served with minimal to no requirements to report efficacy of the services delivered nor the impact to the people being served. **The important question to ask relating to the number of clients served and the number of services delivered is; To what end?**

For example CAL OES requires the reporting of 23 programmatic objectives. Each of which is a number (quantitative) piece of data. E.g. Number of crisis line calls received, total number of individual counselling sessions, total number of DV victims who received emergency food and/or clothing.

CAL OES also asks grantors to respond in narrative to 9 questions. Of which the only question which asks about efficacy of services is; “Provide any information on the evaluation of the effectiveness of your domestic violence programming.” Even though this question gets closer to measuring the efficacy of services it is literally asking to report on the evaluation of efficacy and not on the actual efficacy of services. Therefore, by default **organizations are not required to nor are they being held accountable for evaluating their ability to deliver meaningful, measurable and financially sustainable results for the people the organizations are in existence to serve.**

Quantitative data counts are important for certain things and is relatively easy to gather; however qualitative data is required in order to determine the impact and efficacy of services and is more challenging to gather. In addition the quantitative data currently being collected is in some instances not even reflective of the actual numbers being captured. One example of the problem with this type of reporting is evident with the question: total number of crisis line calls received. The assumption is every crisis line call being counted is from a person in a crisis that is specific to domestic violence. This is not the case. Every day individuals call The Center’s crisis line who are not experiencing IPV, may be calling the wrong number, as well as existing clients who need to reschedule an appointment or be reminded of the date of their next appointment. The result is The Center may report 832 crisis line calls received and it is possible 50% of those calls could be for concerns unrelated to IPV.

Numbers matter however to ensure we are supporting organizations in their efforts to move clients through intervention services into prevention services. It becomes more important to measure the impact services are having on clients through the collection and analysis of relevant qualitative data. Relevant qualitative data would be directly related to; clients being out of crisis, improving client stability, reduction in symptoms related to trauma, increased understanding of the impact of IPV on their children and increasing skills to better help their children. It is also vital to understand which service were used and in what dosage that produced the qualitative outcomes.

Current Data Deficit

78% of funders want impact measurement data

75% of funders rarely if ever cover the costs for providing impact measurement data

67% of Human Service organizations do not regularly collect impact measurement data
Non Profit Finance Fund- 2014 State of the nonprofit sector report

A common belief is the deficit of scientifically sound qualitative data is in part contributing to maintaining the long standing level of IPV recidivism. **The IPV field as a whole has virtually no data re: its collective impact towards the prevention of IPV.** The data deficit occurs in large part because current funding streams force grantees to decide how to cut the funding pie into more pieces.

In the absence of additional funding for increasing organizational capacity for using data; an organization wanting to gather qualitative data to inform service delivery would be caught between a rock and a hard place. To make the invest organizations would need to secure resources for; purchasing data collection software and licensing fees, the identification, acquiring of and required training for implementing appropriate and relevant impact assessments, hiring data analysts and managing the data collection process. Given current CAL OES funding guidelines organizations either are not able to make this investment and ensure its sustainability or would be required to reduce funding allocations for services and staffing.

It is accurate to assume the more IPV agencies use data to accurately understand the service needs of their clients and measure the impact of services, the more able service providers will be to ensure that all of their services and interactions with clients are aligned with the goal of moving clients through intervention services and into prevention services. The use of qualitative data will better enable IPV service providers to identify what works, how it works and for whom it works. This knowledge will also uncover promising practices and provide the opportunity to turn promising practices into best practices.

Promising Practices- Best Practices– an opinion

Over the past few years there seems to be an upswing in the use of terms identifying programs being marketed as and/or referred to as a “best practice” program. Funders seem to be focused more on funding organizations who are using “best practice” programs.

There is an important distinction to be made re: the term best practice. As it relates to services A best practice is a service that has generally been accepted as superior to any alternatives because it produces results that are superior to those achieved by other means. **Many of the programs/services claiming to be a best practice do not meet this definition primarily due to the lack of data validating the opinion that a particular program or service is superior to other similar programs because of its outcomes.** The process for validating the superiority of a particular program is one which requires multiple studies, control groups and a meta-analysis of all data connected to a best practice study. More often than not the term best practice is defined as the standard way of doing things. **In most cases within the IPV field programs claiming to be a best practice are actually a promising practice.** When considering changes to service delivery it is important to clearly define what is meant by best practice and given the lack of genuine best practice programs/services consideration should be given to funding the research and development of promising practices so they may become best practices.

Promising Practice - Programs:

Current IPV funding is focused on crisis intervention services and weighted primarily to adult victims and secondarily to their children. Given this reality it makes sense there is relatively few IPV organizations with the capacity to move victims (adults and children) from crisis intervention services to prevention services. In addition if the desired outcome is the prevention of IPV it is necessary to expand funding for the provision of intervention and prevention services to children and people who perpetuate IPV.

The Center for Violence- Free Relationships has a long history and remains at the forefront in the development, piloting an implementation of specific program for both of these populations.

The Second Generation Project (SGP) – An intervention/prevention program for kids

“When I grow up I’m going to use my muscles to hit my mommy just like my daddy does.”

– 9 year old SGP boy.

Children who experience IPV have significantly higher rates of Post Traumatic Stress Disorder (PTSD) than non-exposed kids. In addition they have higher levels of interpersonal distress, social behavior problems, and a range of issues which impact their ability to perform well in school and create positive relationships with peers. **Evidence suggests failing to address these issues will likely result in them becoming the next generations of IPV victims and/or perpetrators.**

The Second Generation Project (SGP) is a 12-week trauma-focused cognitive behavioral group therapy program for children (ages 8-12) with measurably higher than normal levels of PTSD and their non-abusing parent who are ready to learn how to integrate trauma to reduce its immediate and long term impacts. It is important to note that the trauma integrated does not have to be directly related to IPV rather it can be any incident the child selects as being significant. The Second Generation Project required \$60k and three years of research and development time. The program was peer reviewed by child trauma experts from across the country.

Aggregate Program Outcomes: After receiving a total of 24 hours of therapy over 12 sessions children experienced:

32% reduction in the frequency and severity of their PTSD symptoms

67% reduction in their social problems

43% reduction in their interpersonal distress level

Additionally the outcomes experienced continued to improve one year post graduation.

Positive Solutions- An Intervention/prevention program for people who do harm

Even though The Center has been working with males and females who perpetuate IPV for over 25 year; in spite of some recent movement there seems to still be significant resistance to IPV organizations providing intervention and prevention services to people who do harm. There seems to be a level of acceptance with leaving the delivery of services to those who do harm to the judicial and/or law enforcement whom for the most part operate within a punitive

framework. This punitive framework is relatively pervasive throughout the both the judicial and law enforcement systems. The deeply concerning reality is this punitive approach may actually be increasing harm to some victims.

According to the Blue Shield of California Foundation's recently released study, "Breaking the Cycle: A life course framework for preventing domestic violence", researchers revealed; **Mandatory arrest policies have zero effect on rates of recidivism.** Additionally, a quasi-experimental study comparing states that adopted mandatory arrest policies to those that did not found that **these policies led to a 60% increase in intimate partner homicide.**

The study also concluded: "Expansion into these services (Batterer Intervention programs) is an important new frontier that is necessary to ensure the safety of survivors and to protect child and family health."

Most Batter Intervention Programs (BIP) focus exclusively on behavior change. **The Center's Positive Solutions program focuses on the healing of the individual as well as changing their abusive behaviors.** We recognize behavior more often than not is rooted in early life experiences. If those experiences were abusive, neglectful of the emotional needs of the child and the child experienced separation from one or both parents there is an increased likelihood they will behave in accordance with those experiences. Failing to heal the individual perpetuates recidivism. In support of this two pronged approach The Center is mindful of the language we use to describe this population.

You will note the use of "people who do harm" v. batterers or perpetrators. This is intentional. We do not use the labels of perpetrator or batterer as doing so implies that this is who the individual is rather than the acknowledgment that these are people who are engaging in behavior that is unacceptable and for which they need to be given tools and be held accountable for using them.

An initial study of the Adverse Childhood Experience (ACE) of program participants revealed nearly 50% of participants have an ACE score of 4 or more and 23% have an ACE score of 6 or more. An individual's cumulative ACE score has a strong graded relationship to numerous health, social and behavioral problems throughout their lifespan. To illustrate the impact adverse childhood experiences has on an adult; an individual with 6 or more ACE scores has a 30 fold increase in attempted suicide and a 20 year shorter life expectancy.

Given the high ACE scores of program participants one can safely state the individuals who do harm are survivors of childhood trauma and need to be offered treatment similar to what is offered to adult victims of IPV.

On average there are 200 program participants annually. Currently, 64% of Positive Solutions program participants are court ordered to attend and 36% are voluntary participants. The program is comprised of 52 sessions organized around 3 core competencies: Identification of

behaviors, Where do these behaviors come from, and How do we change behaviors. The lessons structure consists of 30 minutes of education and 90 minutes of practical application of the principal being taught. Facilitators are trained to be very assertive and direct in their approach with a high degree of accountability placed on the participants to complete their weekly out of session work.

Aggregate Program Outcomes:

73% graduation rate

Of the graduates who we are able to survey one year post graduation – 93% of those individuals self-report they have not been re-arrested for IPV and this number seems consistent with available arrest records.

It is important to note that **currently CAL OES funding is not allowed to be used for this program and there are virtually no private funding streams available for this program.** The Center uses unrestricted funding and program participant fees to fully fund this program.

Intervention to Prevention

In the spring of 2018 The Center in partnership with seven organizations across the state developed a 21 question survey incorporating evidenced based assessments designed to help us learn more about the service needs of survivors and how to best move a client from crisis intervention services to prevention services. 520 survivors completed the survey. The Center released, “Domestic Violence, PTSD, and Early Childhood Experiences: What Service Providers need to Know.” Aggregate data from the study provides significant insights to the needs of survivors and the services needed to move into prevention.

Using the original Adverse Childhood Experience (ACE) study results for a comparative baseline Key Findings suggest:

IPV Survivors are 14 x more likely to have 6 or more ACE’s then original ACE study respondents

IPV victims are 5x more likely to have experienced complex childhood trauma

Childhood emotional abuse and emotional neglect may be the highest risk factors for experiencing IPV as an adult- not early exposure to IPV as a child as is commonly believed

+ IPV survivors have a 19% point increase in EVERY type of childhood trauma.

+ 70% of IPV Survivors are experiencing 3 of the 5 symptoms of PTSD. For comparison it should be noted the prevalence of PTSD in veterans receiving care at VA Primary care clinics is 24.5%

+ 69% of IPV Survivors were concerned about an unhealthy relationship before the age of 25

+ 50% of IPV Survivors said they did nothing when they first realized they were in a violent relationship.

+ For 39% of IPV Survivors, the primary prompt to engage in services was an incident of

physical violence and/or law enforcement becoming involved.

Key findings suggest that survivors need services beyond immediate crisis intervention services, especially if the goal is to reduce and eliminate recidivism.

IPV Survivor Service Delivery Recommendations:

Provide additional services designed to address all of the trauma of survivors (including childhood trauma) and not only adult IPV trauma.

Dedicate more resources to providing on site mental health services.

Expand the focus of programs for children to include addressing the impact of all types of trauma and not just the trauma associated with their exposure to IPV.

Recommendations for the State to help providers more effectively serve those affected by IPV

Increase the capacity of the IPV field to use technology to gather data and assess program/service outcomes including ability to use data to inform decision making.

Provide one time multi- year funding for creating a field based hub for the research and development of promising practices to build and share a body of best practice models for use by the field. Incentivize organizations to use the promising/best practice models.

Fund the expansion of promising intervention/prevention programs for people who do harm. Increase the capacity of organizations willing to work with this population so they can bring the programs to locations outside of their immediate service areas.

Reconsider current CAL OES funding guidelines to align with the needs of survivors for the provision of longer term mental health services which address the full scope of trauma.

Research and determine the impact of moving away from peer advocates to certified IPV counselors similar to the CADC certification for substance abuse counselors.