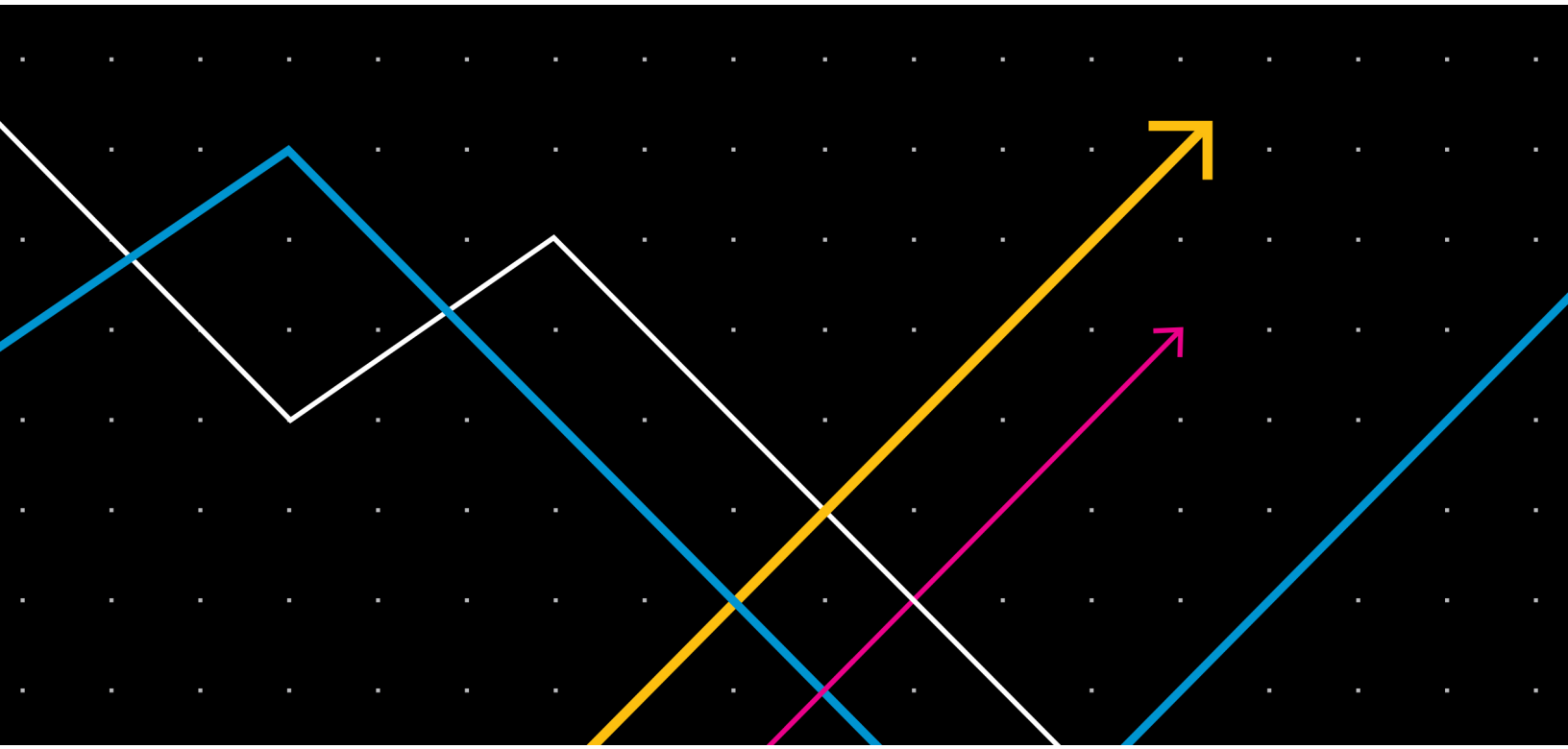

RESEARCH REPORT

A New Nonmandated Program for People Who Cause Intimate Partner Violence

Findings from an Implementation Assessment in New York City

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A New Nonmandated Program for People Who Cause Intimate Partner Violence

In 2020, the New York City Mayor's Office for Economic Opportunity, the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV), and the Human Resources Administration funded the Urban Institute to conduct an implementation assessment of the Respect and Responsibility (R&R) demonstration project, a free nonmandated program for people who cause intimate partner violence (IPV). The R&R program "includes a multi-week intervention and individualized assessments, case management, counseling, and other supportive services,"[1] and is delivered by three program providers: Urban Resource Institute, STEPS to End Family Violence at Rising Ground, and the RISE Project at the Center for Justice Innovation. Urban's goals were to (1) establish a foundation for evaluating the R&R program, (2) assess the curriculum's development, and (3) assess how program providers implement the program. This report advances the third goal and summarizes findings as they relate to the implementation assessment.[2] This report (1) delves into literature describing the state of IPV interventions for people who cause harm and the need for nonmandated interventions, (2) describes the R&R program's background, (3) illustrates the methods Urban used to conduct its assessment, (4) shares findings from the research, and (5) concludes with discussions and recommendations for future R&R programs.

Intimate Partner Violence Programs

Intimate partner violence remains a critical issue across the US. It is estimated that one in four women and one in nine men experience IPV, which includes physical and sexual violence, stalking, and psychological aggression (Huecker et al. 2023**).** In the US, IPV accounts for nearly 15 percent of all violent crime **(**Truman and Morgan 2014). The most prevalent intervention programs for people who cause harm to their partners are batterer intervention programs (BIPs), also called abusive partner intervention programs (APIPs) in New York City, or domestic violence intervention programs. It is estimated that by the early 2000s, there were more than 2,500 BIPs in the country **(**Cheng et al. 2019; Ferraro 2017**;** Murphy, Rosenbaum, and Hamberger 2022**;** Price and Rosenbaum 2009), and around 44 to 47 states had varying guidelines to regulate BIPs (Ferraro 2017; Flasch et al. 2021).

Despite courts' continued reliance on these programs, there is mixed evidence regarding their effectiveness in retaining participants, preventing violence, reducing recidivism rates, and ensuring the safety of survivors. Some studies found positive outcomes. Bennett and colleagues (2007), for example, evaluated rearrest data for nearly 900 men who participated in BIPs and found that, after more than two years, men who completed the programs were around 50 percent less likely to be rearrested for IPV than men who did not. Frequently, however, research on BIPs found only modest decreases in recidivism and future violence (Babcock et al. 2016; Wilson, Feder, and Olaghere 2021). Babcock, Green, and Robie (2004), for example, found that among people causing IPV, those who completed a mandated intervention program were only 5 percent less likely to perpetrate physical violence against a partner than those who did not attend a program. Relatedly, Cheng and colleagues (2019) found that BIP participants were about three times less likely to experience IPV recidivism, but when assessed by the survivors, there was no significant decrease.

Current Batterer Intervention Program Models

The overwhelming majority of BIPs are court-mandated programs for those who have caused harm and entered the criminal legal system as a result (Cheng et al. 2019). State guidelines vary regarding program length, but most states require at least 24 weeks; some require up to 52 weeks (Flasch et al. 2021). Notably, most of the research on the implementation and effectiveness of these programs focuses on male participants (Eckhardt et al. 2006; Zarling, Bannon, and Berta 2019).

THE DULUTH MODEL

Since the advent of IPV intervention programs for people who cause harm, the Duluth Model has been and remains the most common approach (Babcock, Green, and Robie 2004). Created by the Domestic Abuse Intervention Programs in Minnesota, the Duluth Model primarily relies on the "Power and Control Wheel," which emphasizes that abuse and violence are by-products of patriarchy and power and that men who abuse their partners are "acting out of a context of entitlement that has its roots in a history of male individual, group, and institutional control over women" (Pence et al. 2011, 32). The model also often incorporates strategies informed by cognitive-behavioral therapy in its approach, with many techniques focused on altering cognitions, beliefs, and emotions to stymie violent behavior (Adams 1988; Zarling, Bannon, and Berta, 2019; Zarling and Russell 2022). Notably, the Duluth Model is designed to be situated within a "coordinated community response" network that includes "arrests for domestic violence, sanctions against noncompliance to court orders, support and safety planning for

victims, and referral to other agencies with collaborative approaches" (Zarling, Bannon, and Berta 2019, 1).

Despite the predominance of the Duluth Model, research often finds that it often produces limited decreases in recidivism rates among participants (Babcock, Green, and Robie 2004; Herman et al. 2014). The model has also received significant criticism for its one-size-fits-all approach, which often assumes homogeneity among people causing IPV in terms of personality characteristics and types of violent behavior (Cantos and O'Leary 2014; Stuart, Temple, and Moore 2007). As a result, many practitioners and researchers have increasingly called for the implementation of more effective IPV intervention approaches for harm doers (Babcock et al. 2016; Cannon et al. 2016; Radatz et al. 2021; Santirso et al. 2020).

TAILORED EVIDENCE-BASED MODELS

Emerging curricula for BIPs are starting to incorporate tailored evidence-based practices for addressing harm. The Risk-Needs-Responsivity framework is increasingly being used to evaluate how to best intervene (Zarling and Russell 2022). The framework is based on the understanding that treatments should be tailored to each participant's *risk* level; effective programs should target psychological, social, and emotional *needs* of each participant; and program providers should be *responsive* to the learning style, cognitive ability, motivation, personality, and cultural background of each participant (Zarling and Russell 2022).

Following the Risk-Needs-Responsivity principles, IPV intervention program models for harm doers have begun to incorporate cognitive-behavioral approaches, such as "acceptance and commitment therapy" and "Achieving Change Through Values-Based Behavior," which is a departure from the Duluth Model (Berta and Zarling 2019). Rather than focusing only on changing the thoughts and emotions of the participant, these approaches highlight psychological flexibility by exploring new ways of responding to problematic thoughts and emotions (Zarling et al. 2020; Zarling and Russell 2022). Based on data from more than 3,400 men who were arrested for IPV and mandated to attend a BIP, Zarling, Bannon, and Berta (2019) found that, compared to the Duluth Model, significantly fewer participants in programs using the "Achieving Change Through Values-Based Behavior" approach faced new violent charges, despite having a much higher dropout rate.

In an effort to be responsive to people who cause harm in intimate relationships, an increasing number of intervention programs are emphasizing cultural responsivity as part of their models. The Men's Group, for example, is a nonmandated, community-based, and culturally responsive intervention program that primarily serves Latino men in the Chicago area (Davis et al. 2020). This program is

designed specifically to respond to the needs of Latino men. After conducting interviews and focus groups with participants, as well as observing the program sessions, researchers believe The Men's Group shows promise as an "alternative or supplement to traditional BIPs" (Davis et al. 2020). Therefore, it is important to consider how many more programs can be tailored to be responsive to the cultural, social, and economic backgrounds of participants.

Court-Mandated Interventions and Treatment

Batterer intervention programs are not the only court-mandated intervention programs for people who cause IPV. Courts can also mandate mental health and substance abuse treatment programs if an assessment reveals that a person needs such assistance. The assumption with mandated treatments is that people will not participate if they are not legally obligated to do so (Perron and Bright 2008). The evidence on the effectiveness of legally mandated treatments for mental health and substance abuse is mixed. Some studies espouse the need for mandated programs to guarantee participation and reduce program dropout rates (Kelly, Finney, and Moos 2005; Miller and Flaherty 2000; Perron and Bright 2008). For example, Coviello and colleagues (2013) found that, despite expressing far less motivation, those who were mandated by the criminal legal system to enter a community-based outpatient treatment for substance abuse were much more likely to complete the treatment than those who entered voluntarily.

Some scholars, however, found that mandatory participation was often insufficient to secure continued engagement from participants (Beckerman and Fontana 2001; Howard and McCaughrin 1996; Swartz, Swanson, and Hannon 2003). Additionally, some researchers observed long-term consequences for court-mandated treatments. After analyzing surveys from 104 individuals with schizophrenia-spectrum conditions, Swartz, Swanson, and Hannon (2003) noted that those with a history of being involuntarily hospitalized were significantly more reluctant to seek outpatient treatment.

Given the mixed evidence on mandated intervention programs for mental health and substance abuse cases, there is a need for research to assess and document the implementation of nonmandated intervention programs for people who cause intimate partner violence.

The Need for Voluntary Interventions

The challenge with mandating IPV intervention programs for harm doers is that IPV needs to be reported to law enforcement in order for a mandate to occur. Although a greater percentage of IPV survivors reported their experience to police in 2021 (50.7 percent) than in 2020 (41.4 percent) (Thompson and Tapp 2022), many instances of IPV go unreported (Morgan and Truman 2020). Research demonstrates that survivors, including immigrants and transgender people, are unlikely to formally share their experience with either service providers or law enforcement (Addington 2022; Alvarez et al. 2018; Cho et al. 2020; Dolan and Conroy 2021; Kennedy et al. 2023). Survivors often fear reporting IPV because they believe the police would either arrest them or do nothing (Goodmark 2022). In addition, many survivors fear what may happen to their abusive partners if they become involved in the criminal legal system (Ervin and Henderson 2020; Huecker et al. 2023). Given the fact that many harm doers often are not placed in courtrooms to be mandated to attend intervention programs, the IPV field should consider nonmandated approaches to IPV interventions.

New research demonstrates that nonmandated and voluntary approaches for people who cause harm may hold promise. As mentioned previously, Davis and colleagues (2019) conducted a case study of how The Men's Group functioned, and they found that participants anticipated and desired to engage in the program long term after being involved. Additionally, Wong and Bouchard (2020), in the pilot evaluation of the Men in Healthy Relationships program in British Columbia, Canada, demonstrated that participants showed a considerable decrease in abusive behavior after engaging with the program.

The Respect and Responsibility Demonstration Project

To date, the Respect and Responsibility demonstration project is the first program in New York City to operate as a nonmandated intervention program for those who have caused harm or are causing harm in their intimate relationships. The target population of the R&R program is broad and comprehensive. The only groups excluded are those legally required to attend an IPV intervention program for people who cause harm, under the age of 18, and residing outside New York City. As stated in its mission, the initiative is intended to optimize voluntary engagement for people of all gender identities who no longer want to cause harm in their relationships.

The R&R curriculum incorporates some trauma-informed and restorative justice approaches into its model, and it was created by staff at the three provider agencies and a curriculum developer, MindOpen Learning Strategies.[3] By incorporating the "responsivity" principle of the Risk-Needs-

Responsivity framework, the curriculum was designed—alongside intentionally selected and trusted community providers—to support participants across a broad spectrum of lived experiences with IPV. Additionally, R&R program providers developed the curriculum with a community-level change approach, which centers on self-care and community care, while validating the realities of groups directly impacted by structural inequality and oppression or of members of marginalized groups.

This report documents the implementation assessment of the R&R program and adds to the body of research on nonmandated BIPs and trauma-informed and community and culturally responsive approaches to IPV interventions.

Implementation Assessment of the R&R Program

In 2019, the New York City Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV) put out a request for proposals (RFP) to community-based organizations to implement the Respect and Responsibility demonstration project. The R&R project was part of then–first lady of New York City Chirlane McCray's Interrupting Violence at Home initiative. During Urban's study, stakeholders reported that this initiative was established to address IPV in community settings and outside the criminal legal system. The initiative included four parts: (1) create a Respect First initiative, a forthcoming IPV program for young people who cause harm in family or dating relationships and are either mandated by family court or voluntarily seek intervention; (2) work across the Crisis Management System sites, along with their credible messengers, to coordinate IPV services and build their capacity to address IPV in violence interruption work;[4] (3) develop a restorative justice blueprint after convening and learning from service providers that are doing work around restorative justice and IPV (Sasson and Allen 2020); and (4) implement the R&R program.

In November 2020, STEPS to End Family Violence at Rising Ground, the RISE Project at the Center for Justice Innovation, and Urban Resource Institute[5] were chosen to pilot the R&R program. In the first part of the assessment, Urban worked to establish a foundation for evaluating the Respect and Responsibility demonstration initiative. Urban created, alongside program providers, a logic model depicting the program's inputs, activities, outputs, and intended short- and long-term goals. The intended short- and long-term outcomes of the R&R program are shown in figure 1. (See appendix A for the latest draft of the full logic model.)

FIGURE 1

The Respect and Responsibility Program's Intended Short- and Long-Term Outcomes

Intended short-term outcomes	Intended long-term outcomes
•Observed changes in accountability •Increased level of engagement, including program attendance, participation, and working with others •Increased understanding of structural oppression •Increased understanding of self •Increased knowledge of what abuse means •Reached people who may not have been engaged by other programs to understand their needs	•Reduced IPV in New York City •Increased program participation •Increased access to trauma-informed and culturally specific programs outside the criminal legal system •Changed abusive attitudes and behaviors •Increased self-awareness for harm doers •Increased social networks among peers

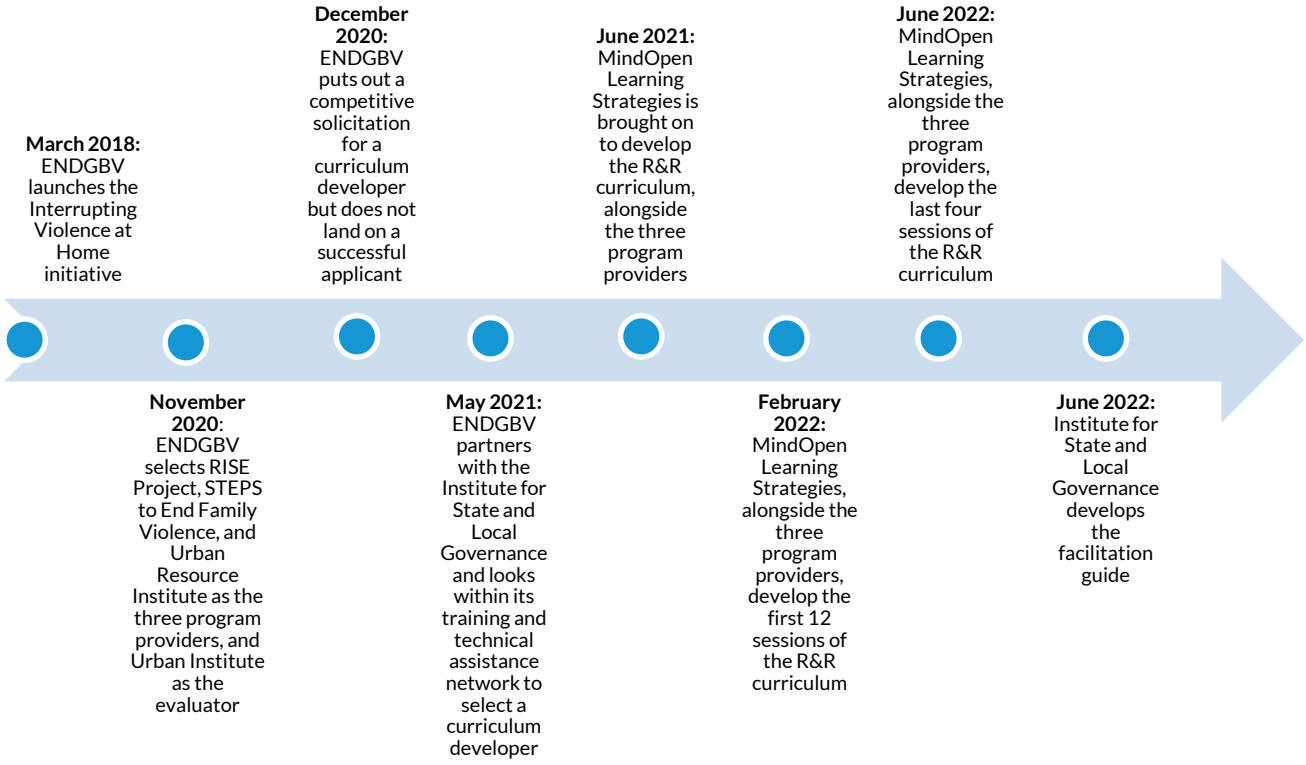
Note: IPV = intimate partner violence.

Before the COVID-19 pandemic, the RFP established population targets for providers: they were to serve 420 participants annually through their introductory course at off-site community settings. Furthermore, each provider was to serve 150 participants annually through "multi-week or multi-hour courses with on-site, trauma-informed, short-term case management and counseling services" (per the evaluation RFP). However, because of the COVID-19 pandemic and other challenges, providers were not able to meet these targets. (See later sections for further details.)

A unique challenge early in the program was the absence of a curriculum and a curriculum developer. ENDGBV solicited for a curriculum developer on several occasions but was unable to find one that could develop a community-based curriculum that existed outside the criminal legal context through the city's procurement process. Therefore, ENDGBV worked with its partners at the Institute for State and Local Governance to search within the institute's training and technical assistance network. In summer 2021, MindOpen Learning Strategies was brought on to develop the R&R curriculum; figure 2 depicts the curriculum development timeline. In early 2022, MindOpen Learning Strategies developed the first 12 sessions, alongside the three providers, the Institute for State and Local Governance, and ENDGBV. The remaining four sessions were developed by this collaborative later in 2022. The curriculum uses a voluntary "grab bag" model, meaning providers are given the option to select a curriculum topic of their choosing for each session or not use the curriculum at all. Providers were not mandated to use the curriculum or to follow the order of the sessions as outlined.

FIGURE 2

Timeline of Major Milestones in the Development of the Respect and Responsibility Curriculum



Source: Erica Henderson and Storm Ervin, "Respect and Responsibility Curriculum Development," internal memo, Urban Institute, September 2022.
Note: ENDGBV = New York City Mayor's Office to End Domestic and Gender-Based Violence. R&R = Respect and Responsibility demonstration project.

As the curriculum developed and the program moved closer to a start date, providers began to think about outreach and recruitment strategies. They had to grapple with recruiting people who had caused harm to their partners as well as those who self-identified as at risk of causing harm to their partners but were not currently involved in the legal system—all during a global pandemic. Providers employed innovative recruiting strategies. They sought out individuals at faith-based organizations and barbershops. In addition, they conducted outreach events at other organizations, such as the Administration for Children's Services and the Family Justice Centers. They also conducted outreach events in neighborhoods of interest, such as block parties or other community events. Finally, they recruited from other areas of their organizations; for instance, one provider reported recruiting alumni from another program led by their organization.

In 2022, once the providers began holding sessions, Urban initiated the second part of its study: assessing the implementation of the program. Urban's research was guided by the following questions:

1. How is the R&R program implemented?
2. To what extent does the implementation differ across providers?
3. What is the difference between the individual (multihour) and group (multiweek) curriculum sessions?
4. Who is the target audience for the multi-hour and multi-week sessions?
5. What is and is not working with the current R&R program operations?
6. What are the providers' implementation challenges?
7. To what extent is the R&R program meeting its intended goals and outcomes?
8. To what extent does participation in programs affect outcomes?
9. What additional supports exist for participants and are they helpful?

Methodology

Urban employed a mixed-methods approach to conduct this research, including both qualitative and quantitative data collection and analysis. Box 1 describes the activities and methods used.

BOX1

Data-Collection Activities and Methods

Between March 2022 and October 2023, Urban conducted the following research activities to assess the implementation of the R&R program:

- **Daily facilitator questionnaire.** Urban requested program facilitators to complete an online questionnaire through Qualtrics survey software after each session, documenting topics covered, use of the developed curriculum, and successes and challenges perceived. Over the course of the program, 14 facilitators had access to the survey; though, there was some turnover.
- **Programmatic administrative data**. Each quarter, staff at ENDGBV sent Urban deidentified data, recorded in a system called IRM, from each provider that included participants' referral sources, demographic characteristics, program engagement and completion, and additional supportive services. Urban also requested aggregate programmatic data from providers to verify the data in the IRM.
- **Focus groups with participants**. Urban conducted two focus groups with program participants and an interview with one participant who was unable to attend the scheduled focus groups (11 participants in total).
- **Interviews with stakeholders**. Urban conducted interviews with nine stakeholders from provider and funding organizations.

Summary of Data Collection

Urban's data collection for the implementation assessment began in March 2022 and lasted through October 2023. The data collected consisted of a daily questionnaire completed by program facilitators; data from ENDGBV's web-based data-collection tool called IRM, which included participant data and their session involvement over time; interviews with stakeholders; and focus groups with participants and an interview with one participant. Urban also received participation data directly from providers, although in some cases, providers did not have data available, or their data did not align with numbers reported in the IRM or the facilitator questionnaire. In summary, Urban

- analyzed data for 129 participants across services rendered by three providers through the IRM and aggregate data reports from providers;
- analyzed 244 completed facilitator questionnaire surveys, of which 237 were completed and 7 were partially completed6 (table 1 summarizes survey entries by provider);
- thematically analyzed interviews with nine stakeholders; and
- thematically analyzed focus groups and an interview with 11 participants.

TABLE 1

Facilitator Questionnaire Completion by Provider

	Partially completed	Totally completed	Total
Provider			
A	1	57	58
B	6	145	151
C	0	35	35
Total	7	237	244

Source: Results of the "Facilitator Questionnaire" developed by the Urban Institute.

Findings

The sections below summarize key findings and provide detailed results of Urban's implementation assessment of the R&R program in its first 20 months of implementation.[7] Across providers, program implementation generally followed the same structure in terms of outreach and the types of sessions offered. Demographics varied slightly across providers, but they mostly followed similar patterns. All providers faced challenges with enrollment and attrition. Each provider made use of the R&R curriculum in their own way, but the "Understanding Intimate Partner Violence" and "Trauma and Healing" modules, as well as facilitator-designed approaches (not included in the modules), were most often used. In general, providers saw that the R&R sessions went well and that participants were engaged. Though we only spoke to 11, participants overwhelmingly appreciated the program and

reported a desire to work toward changing their behavior; they also identified some program areas to improve. Both participants and stakeholders reported several overall successes and some challenges.

PROGRAM IMPLEMENTATION

Program providers were not required to implement the R&R program in the same way, but ultimately some universal practices arose. Each provider submitted a separate proposal to implement the program; though, there were some overlapping goals as mandated by ENDGBV's RFP. For instance, providers were expected to serve 150 participants annually through either "the multi-week or multi-hour courses with on-site, trauma-informed, short-term case management and counseling services" (per the evaluation RFP). Through analysis of interviews, the IRM data, and facilitator questionnaire, Urban found that the program was implemented similarly across providers. This section highlights findings as they relate to multiweek (open and closed group sessions) and multihour (counseling) sessions, referrals, and the program's service population.

TYPES OF PROGRAMS

R&R sessions (or multiweek programming) consist of an intake session and three types of group sessions: introductory sessions, open group sessions, and closed group sessions. For intake sessions, providers met with individual participants to assess needs and readiness for the program, consider referrals, and set the foundation for case management services.

Group sessions would begin as an open group, meaning anyone can join (or come to the session), but eventually at some point they would be closed (open only to individuals who attended previous sessions).

The way we do it is, we have the option of the group being open until the third week, and then we close the group after that, cause at that point, that's when the topics become a little bit more intimate, and the group already has cohesion. —Stakeholder

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The three sessions lasted around 12 weeks.[8] In the sessions, a facilitator guided the participants through aspects of the curriculum and other related content as the facilitator saw fit. According to internal data reports that the providers shared with Urban, collectively, they delivered 172 closed group sessions, 27 open group sessions, and 6 introductory sessions.[9]

Though each provider had introductory sessions, implementation of these sessions evolved by provider as the program progressed. Provider A kept the introductory sessions separate from the group sessions and reported using them as a way to recruit and register participants. Providers B and C eventually combined the introductory session into the 12 weeks.

One provider began with introductory sessions, but after about two of these sessions, its staff found that they were not necessary and it was better to go directly into the group sessions. A staff member stated that "given the ambivalence, shame, and resistance to engage in groups like ours, we think it's better to 'get started, jump right in' as opposed to 'try this one session and see if you want to come back for more' kind of approach." Similarly, the last provider combined the introductory sessions into the 12 group sessions—making the first of the 12 sessions the introductory session—and instead used the intake session beforehand to orient and prepare participants individually for the 12 sessions. According to providers' internal data, there were 6 introductory sessions across 2 providers and 129 intake sessions across all providers.[10]

All providers conducted virtual sessions, and one provider conducted both virtual and in-person sessions. The program was intended to be in person. However, because of the COVID-19 pandemic, all providers began with virtual sessions, and all but one continued to have virtual sessions. The in-person sessions conducted by one provider were held in Brooklyn and the Bronx. According to the facilitator questionnaire, there were 205 virtual sessions and 32 in-person sessions. Additionally, one provider offered sessions in Spanish to accommodate their participants' language needs. In total, there were 16 sessions in Spanish, all of which were closed group sessions. Most of the sessions held were closed group sessions (n=172), followed by 27 open group sessions, and 6 introductory sessions.[11] On average, each session had three people in attendance, with a maximum of 12 and a minimum of zero.

In addition to the group sessions, all providers offered individual counseling sessions to participants. Participants were offered individual, multihour counseling sessions, both while attending group sessions and up to two to six months after completing group sessions. When reflecting on individual and group sessions with R&R participants, one stakeholder recalled the types of things they discussed in those sessions:

> A lot of what has come up for them with these difficult emotions and processing the harm they've caused starts a lot from their childhood. So, we would process from there. Like what does that mean? What is your concept of healthy relationships? And how can you get back to that point where you can really have open communication and trust and all these values? So, it really goes from the moments of where they were referred and what brought them here and what keeps them here, but really looking at throughout their whole life.

According to providers' internal data, across two providers, there were 192 counseling sessions. One provider did not report offering counseling sessions.

Providers reported also offering trauma-informed case management services to participants. Some of these services consisted of assessing needs and making appropriate referrals. According to providers' internal data, two providers provided case management services 174 times and another provided them to 13 people.[12]

Table 2 lists the types and frequency of programs administered by providers. The numbers in in table 2 are from data reported directly from providers, not from the IRM or facilitator data.

TABLE 2

Frequency and Type of Programs Administered

	Frequency
Type of program	
Counseling session	192
Case management	174[a]
Closed group session	172
Intake Session	129
Open group session	27
Introductory session	6

Source: Participation data provided to Urban by providers.

Note: [a] One provider provided case management services to 13 people and did not record the number of times they provided this service. The number here is lower than the actual number of times providers provided case management services.

Participants were referred to or found out about the R&R program through a variety of sources. Some of the most frequent referral sources were RISE outreach, self-referral, and the Administration for Children's Services. Table 3 gives a full breakdown of referral sources.

TABLE 3

Respect and Responsibility Program Referral Sources

	Percentage	Frequency
Referral source		
RISE outreach	31.00%	39
Self-referral	24.00%	30
Administration for Children's Services	13.00%	16
Guns Down, Life Up	6.00%	8
Strong Starts Court Initiative	4.00%	5
Community-based organization	3.20%	4
Neighborhood Defender Service of Harlem	3.20%	4
Bronx Defenders	2.40%	3
Catholic Guardian Services	1.60%	2
Osborne Association	1.60%	2
Outreach educator	1.60%	2
Staten Island Youth Justice Center	1.60%	2
Bronxworks	0.79%	1
Brooklyn Defender Services	0.79%	1
Buenviaje Counseling	0.79%	1
CAMBA (Church Avenue Merchant Block Association)	0.79%	1
Center for Family Representation	0.79%	1
Center for Family Representation New York	0.79%	1
Rock Safe Streets	0.79%	1
Court system	0.79%	1
STEPS Community Based Services Program	0.79%	1
Therapist/mental health professional	0.79%	1

Source: IRM Data provided to Urban by the New York City Mayor's Office to End Domestic and Gender-Based Violence.
Note: N=127, with referral source missing for 2 participants.

Participants often received referrals to other programs after engaging with the R&R program. Two providers reported offering referrals to participants. Provider B mentioned it was able to make "warm handoffs" to one of 55 other programs within its network. Additionally, providers referred participants to external services and resources, such as counseling services and other organizations (e.g., Downtown Brooklyn Center, Fortune Society, the Violence Intervention Program, and Rising Ground's Fatherhood Initiative).

THE SERVICE POPULATION

According to IRM data, 129 participants received services during Urban's study period, the majority of whom were African American/Black (54 percent) and Hispanic/Latino/Latina/Latine/Latinx (32 percent). Only around 4 percent were white, 3 percent were Asian, and 7 percent were other races,

including Russian, Afro-Caribbean, Middle Eastern, Native American, or multiracial.[13] Most participants identified as male (74 percent). Although 2.5 percent of participants identified as transgender, data related to sexual orientation or identity were not collected. Participants were between the ages of 18 and 61, with an average age of 28. A breakdown of participant demographics by provider is given in the next section.

Consistent with IRM data, stakeholders reported primarily serving young, cisgender men of color. Information that stakeholders shared about their participants included the following:

> [Our participants are] usually 18 to 35. Every so often we might get somebody who is above that age range in a group. We've had participants as old as 56, and a good portion of our participants have been cisgender. I think that we have engaged like very few transgender identifying folks. I think that there is a mix of sexual orientation.

> A lot of the people that we serve are, I don't want to say high-risk people, but are people of color minority, low-income people who are scared of, you know, court involvement. And when they're out talking to their social worker or they're talking to a community leader or just anyone that they can get help from and they get a program that it's like, oh, you can go here.

> Yeah, [in our program] there are almost entirely men. We did take a couple of women at the beginning. But our groups tend to be mostly men between mid-20s to late 40s. I would say it is the most of what we've seen.... We haven't seen a ton of white participants. A mix of others, Latino, Black, Asian, um, first generation immigrants. Some people immigrated themselves. Working class, middle class, working middle class. And say half of them are married, half are not. I say I'll have a lot of troubled marriage situations going on or split marriages, that kind of situation. Maybe a third of them are parents? I would say, like, maybe around like half of them are often parents, maybe even more than half of them are parents.

Most participants had some form of employment (58 percent), whether full time, part time, or in another capacity. For those not employed, 11 percent were students, 4 percent did not report an employment status, and 27 percent were unemployed.

Most participants had a high school diploma or equivalent (31 percent). For those who reported their education, 24 percent had an associate's degree or higher, 16 percent had taken some high school courses, and 14 percent had taken some college courses. Some participants did not report their educational attainment (n=11). Other participant data included whether participants had a history of substance use, mental-health-related concerns, or criminal legal system involvement. Table 4 gives a full breakdown of participant information.

TABLE 4

Characteristics of Respect and Responsibility Program Participants

	Percentage	Frequency
Participant details		
Gender identity		
Man	74%	95
Woman	26%	33
Transgender	2.5%	3
Race		
Black/African American	54%	64
Hispanic/Latino/Latina/Latine/Latinx	32%	38
Other	7%	8
White	4%	5
Asian/Pacific Islander	3%	4
Other characteristics		
History of substance use	22%	23
Mental health needs	17%	13
Previous court system involvement	67%	71
Age	Min. = 18; max. = 61; average = 28	

Source: IRM data provided to Urban by the New York City Mayor's Office to End Domestic and Gender-Based Violence.

Providers reported that their participants resided in all five boroughs, and one provider mentioned having participants from Staten Island. The provider mentioned that Staten Island participants were recruited from a Crisis Management System site there.

Providers reported relatively low enrollment and completion numbers as key challenges to implementation, but they were able to engage with more people during outreach activities than with participants who eventually enrolled. In interviews, providers reported having between 20 and 50 cases, depending on the provider. They named exclusion criteria as a reason for the low enrollment. For instance, providers had to turn away interested participants who have been mandated to attend some form of intervention program, because R&R program is a nonmandated program and cannot penalize participants for not attending. Furthermore, the R&R program rolled out at the height of the COVID-19 pandemic, and remote engagement presented both strengths and challenges. Providers also could not enroll participants, even remotely, if they were not a New York City resident, while remote participation was an advantage for some participants based in the city. In addition, one provider reported that because only adults were eligible for the program, they could not enroll individuals under the age of 18 who were interested. Finally, attrition led to even lower completion numbers. In line with the facilitator questionnaire data, where facilitators reported having a minimum of zero participants,

providers reported at times having none or only one participant show up for a session. Two stakeholders shared,

> So, the participant really wants to do such work, but they are mandated or have been given sort of like a consequence if they are not involved in the program or complete the program and they'll be penalized for it, that wouldn't be a participant that would be appropriate because we're a voluntary program.
>
> I know we had over a hundred enrolled. Like our interest, but never like, you know, not everybody completes.

Implementation Differences across Providers

As previously stated, providers were allowed to implement the R&R program in ways they believed met their participants' needs. This section describes some of the dissimilarities among providers based on interviews, IRM data, and the facilitator questionnaire.

DIFFERENCES IN PROGRAM IMPLEMENTATION

Providers had differences in their 12-week group sessions. Group sessions where the curriculum was administered) lasted 12 weeks**.** Two providers (A and C) described the first three weeks as open groups—or drop-in sessions—and the remaining nine weeks as closed groups, open only to those who attended during the first three weeks. For these providers, sessions in the first three weeks were a way to build rapport and "safety" among participants before they engaged in closed group sessions, which went deeper into addressing harm. They shared that "the way we do it is we have the option of the group being open until the third week, and then we close the group after that. Cause at that point, that's when the topics become a little bit more intimate, and the group already has cohesion." The third provider, provider B, because of challenges in getting people to come to open groups, reported focusing their time and energy on closed group sessions, forgoing open group sessions.

DIFFERENCES IN SERVICE POPULATIONS

All providers served and targeted people who caused harm in their relationships, but each also recruited a unique population. One provider served Spanish-speaking participants. Another recruited people working at Crisis Management System sites, while a different provider recruited individuals who completed their mandated program but wished to continue attending an intervention program.

Providers reported serving mostly young men of color, though the demographics varied by provider. The IRM data included participants' demographic information for each provider. For provider A, there were 54 participants in its multiweek sessions (n=69), counseling sessions (n=4), and other

services, including case management, intake, and introductory sessions (*n*=59). The provider's facilitators reported in their facilitator questionnaire that participant engagement was high during the sessions (giving an average engagement rating of 9.5 out of 10) and that the group was generally going very well (giving an average rating of 9.6 out of 10). Table 5 summarizes provider A's participant demographics.

TABLE 5

Provider A Participant Demographics

	Percentage of participants
Race	
African American/Black	78%
Hispanic/Latino/a/e/x	15%
Asian/Pacific Islander	0%
White	0%
Other	7%
Sex	
Male	59%
Female	41%
Age	Min. = 18; max. = 54; average = 23

Source: IRM Data provided to Urban by the New York City Mayor's Office to End Domestic and Gender-Based Violence.

For provider B, there were 49 participants in its multiweek sessions (*n*=27), counseling sessions, (*n*=16), and other services (*n*=51). The provider's facilitators reported that participant engagement was good (giving an average engagement rating of 8.1 out of 10) and that the group was generally going well (giving an average rating of 7.3 out of 10). Table 6 summarizes provider B's participant demographics.

TABLE 6

Provider B Participant Demographics

	Percentage of participants
Race	
African American/Black	27.1%
Hispanic/Latino/a/e/x	52.1%
Asian/Pacific Islander	8.0%
White	4.0%
Other	8.0%
Sex	
Male	83.0%
Female	7.0%
Age	Min. = 18; max. = 50; average = 31

Source: IRM data provided to Urban by the New York City Mayor's Office to End Domestic and Gender-Based Violence.

For provider C, there were 26 participants in its multiweek sessions (*n*=14) and other services (*n*=10). The provider's facilitators reported that participant engagement was good (giving an average engagement rating of 8 out of 10) and that the group was generally going well (giving an average rating of 8.3 out of 10). Table 7 summarizes provider C's participant demographics.

TABLE 7

Provider C Participant Demographics

	Percentage of participants
Race	
African American/Black	74%
Hispanic/Latino/a/e/x	11%
Asian/Pacific Islander	0%
White	16%
Other	0%
Sex	
Male	90%
Female	10%
Age	Min. = 21; max. = 61; average = 38

Source: IRM data provided to Urban by the New York City Mayor's Office to End Domestic and Gender-Based Violence.

Curriculum and Facilitation

Because providers were using a new curriculum to implement a voluntary IPV intervention program for people who cause harm, it was important to understand how the curriculum was used. Urban relied on interview and facilitator questionnaire data to assess the program's implementation, successes, and challenges. This section presents findings as they relate to providers' use and perceptions of the R&R curriculum.

Providers relied on the curriculum, though it was voluntary, and there were certain aspects they found particularly useful. During interviews, providers reported they favored certain modules, such as "Mind/Body Connection," "Motivation for Change," and "Intergenerational Trauma." Stakeholders' perceptions of the curriculum included the following:

> I think that the way that the curriculum introduces the topic, "Motivation for Change" I think is like really helpful. I love that it's so early in the conversation. I think that we talk about like long term, being somewhere for 12 weeks, talking about why you're here is so important in the beginning.

> I think we talk about intergenerational patterns and stuff that's in the group curriculum, which I think is deep. That's like pretty deep therapeutic technique.

> I think people like the idea of doing the "Mind/Body Connection," where they do the scan. That really helps people really get in touch with themselves more. It'd just be more, more awareness and mindfulness. That has been a really strong part.

Providers used the curriculum in 87 percent of the program sessions, according to the facilitator questionnaire. The most used module was "Understanding Intimate Partner Violence" (*n*=76), while the least used were "Identity, Society, and Power (Intersectionality)" (*n*=8) and "Violence and Gender Expectations" (*n*=8). In some sessions, such as in orientation and close-out sessions, providers did not use the curriculum modules; instead, they used other content based on the needs of the group, such as the impact of IPV on children, participant check-ins and self-reflection exercises, and expanded conversations on accountability. Table 8 lists the modules providers used.

TABLE 8

Frequency of Curriculum Modules Used by Providers

	Frequency
Curriculum module	
Understanding Intimate Partner Violence	76
Trauma and Healing	67
Other (not part of curriculum)	44
Introduction to Accountability	38
Motivation for Change	35
Community Agreements	22
Mind/Body Connection	16
Introduction to Gender Expectations	15
Healthy Communication Skills	11
Intergenerational Trauma and Resilience	9
Identity, Society, and Power (Intersectionality)	8
Violence and Gender Expectations	8

Source: Results of the "Facilitator Questionnaire" developed by the Urban Institute.

Providers reported aspects of the curriculum that were not applicable to the community or that were not thoroughly addressed. Providers' major concern was language accessibility. For instance, they described how the curriculum's content was, at times, "a little too academic." Relatedly, they reported that the curriculum did not have a Spanish version. Translating concepts and ideas from English to Spanish proved challenging for the one provider that held Spanish-speaking group sessions. Another issue was that the curriculum around power and privilege was not always applicable to their participants; specifically, it does not applicably demonstrate the privileges held by young men of color. Finally, providers wished that the curriculum touched more on parenting. Stakeholders shared the following about the curriculum:

> And another thing missing is the Spanish aspect.

> [The curriculum is] a great baseline. It just feels sometimes a little bit disconnected from community. It's a lot more work we have to do to break down some of the concepts that's in R&R to make it accessible for the community.
>
> The whole section about privilege and identity and oppression, the way the R&R curriculum talks about it, it treats it very much like a college classroom, and we're not about to have to be marginalized communities do a privilege walk.... There are just certain things that you just wouldn't do in community that might be great for like the DEI thing in college.

Providers had mixed feelings around how the curriculum tackled accountability. Two providers commented on how the section on accountability seemed to tackle the issue differently from other intervention programs. These providers reported contradicting views. One reported that the curriculum's approach felt more in line with restorative justice practices and less in line with traditional BIP approaches and applauded it; the other felt that the curriculum did not touch enough on self-accountability**:**

> I like circle practice, so it has circle practice in it, which feels to me a little different than just straight like group therapy, accountability group stuff, which I think could be complicated.
>
> The introductory to accountability needs work cause a lot of it talked about community-based violence or seeing or witnessing the DV [domestic violence] in community, so it's a lot about talking about like, if you were to witness a DV incident or like intimate partner violent incident in community, will you be an upstander or bystander? There's not a lot of accountability conversation about yourself, like you're coming to this group for a reason. Where is the self-accountability?

Providers were encouraged that they were able to modify the curriculum to fit their participants' needs. Providers reported that "the ability to pivot is super important" and gave examples of how they broke down some content that seemed "a little too academic." In other instances, providers reported drifting away from the planned content once they met with participants and realized their immediate concerns would not be addressed by the day's topic. Lastly, when providers realized that important topics like parenting were missing, they incorporated related content. Stakeholders' responses about modifying curriculum included the following:

> I think the opening quote idea works really well. There are times where we've been, like, this quote is maybe a little too academic. Whatever, we change it. But that structure works.
>
> I actually did the trauma part one session last week. And, you know, I came in like this is the curriculum. And what ended up happening with the participants was, here's what we're going through and here's how this thing shows up. And it's like, oh well, forget the curriculum. That's, you know what I mean, I'm going to find these things for you.
>
> I think certain topics have been left out, where we have seen, for example, parenting is a very big, um, part of many of the lives of our participants, which we have not seen as a topic. So, we included that.

FACILITATION TOOLS

Providers reported using several facilitation tools to aid their delivery. Providers overwhelmingly applauded hosting and facilitating circles rooted in restorative practices. They relied on a number of tools to assist them, including using jamboards and whiteboards to build lists, annotating slides on Google, providing worksheets, watching videos and reflecting on them, and probing participants to engage with their peers. Some tools used to inform their delivery included group psychotherapy modality and restorative justice practices. Finally, providers reported using the "Power and Control Wheel," a key element of the Duluth Model, and motivational interviewing. Table 9 lists the tools providers used. Stakeholders' feedback on the tools they used included the following:

> [We used] the "Power Control Wheel," the motivational interviewing. We use a lot of worksheets, and a lot of the activities that were in the curriculum before it was edited. A lot of those are used, those reflective questions. Sometimes we utilize resources like on the internet, so videos that the participants can watch and, you know, give their reflection on.

> We love a jamboard, you know, in terms of being able to do like whiteboarding style, list building activities, like, it's golden for that. Well, I think in the past we have also even just used the annotate [feature] within Zoom, Google slides, YouTube.

> I think I use a lot of group psychotherapy modality, so like really a lot of psychodynamic modality is in the room…. We use a lot of like group therapy techniques and I really mean it's a circle practice…. I guess that could also be like modeling and joining with people, and all of those things come up as we talk about, as we engage in a group, and those are all techniques that are intentionally used to engage people in a different kind of way.

TABLE 9

Frequency of Facilitation Tools Used

	Frequency
Facilitation tool	
Peer-led discussion	128
Reflection on material	110
Circles	102
Reflection on videos	38
Other	34
Physical activities	6

Source: Results of the "Facilitator Questionnaire" developed by the Urban Institute.

One standout activity raised by both providers and participants was letter writing, an activity created by one provider. This provider thought the curriculum did not adequately address accountability and so created a letter-writing activity, where participants wrote letters to themselves "about why they're here and what they hope to achieve during their time here." Participants were also asked to write hypothetical letters to someone they had harmed. Both the provider and participants indicated that this activity was meant to address the harm participants had caused and that the letters were not intended to be delivered to the people who had been harmed. During focus groups with participants, this activity was applauded.

Providers reported often leaning on trainings and content from the Family Peace Initiative (FPI). In 2022, as the R&R curriculum was being developed, providers received trainings from the FPI, House of Ruth in Baltimore, and Futures Without Violence to inform their R&R facilitation methods. During interviews, providers reported that they relied mostly on the FPI's trainings to facilitate. The FPI provides trainings for BIP professionals across the country on topics related to facilitation and delivery,[14] and it trained R&R staff on three of their facilitator training modules: "The Art of Facilitation," "The Affective Component," and "Mastering the FPI Approach." Providers stated they frequently relied on FPI activities, worksheets, and accountability approaches:

> I would say the foundations are probably that curriculum we started with and that gives us the overall sort of mark of things, and then heavily informed by the activities and processes of FPI.

> We adapted and worked a lot with FPI's approach. FPI sort of has, almost like it in certain ways, not the be all and end all, but in certain ways they've sort of cracked the code on what [and] how accountability work is supposed to do. You know, they have their funnels. They have so many, really developed processes that take something that can often feel a little bit like, how do you do this, like they kind of have like the art and science of it. So, we work a lot with FPI's curricula, and then we are also just kind of, we try to stay like sort of open and informed.

CURRICULUM USE BY PROVIDER

As stated previously, providers were not required to use the curriculum. They were encouraged to use it in a way that made sense for their participants. Table 10 breaks down how often each provider used the different modules in the curriculum.

TABLE 10

Frequency of Modules Used by Each Provider

	Provider A	Provider B	Provider C
Module			
Community Agreements	7	14	1
Healthy Communication Skills	1	10	0
Identity, Society, and Power (Intersectionality)	5	0	3
Intergenerational Trauma and Resilience	4	3	2
Introduction to Accountability	5	32	1
Introduction to Gender Expectations	2	12	1
Mind/Body Connection	8	7	1
Motivation for Change	9	25	1
Other (not part of the curriculum)	0	30	14
Trauma and Healing	12	49	6
Understanding Intimate Partner Violence	16	52	8
Violence and Gender Expectations	2	6	0

Source: Results of the "Facilitator Questionnaire" developed by the Urban Institute.

Participant Feedback on the R&R Program

Overall, the 10 participants in the focus groups and one interview participant (*n*=11) had positive reflections about their experience in the program. They stated that the curriculum and the facilitation staff were successes of the program. Additionally, many of them identified positive behavioral changes as a result of the sessions they attended. They also identified ways that the R&R program can increase participation, such as conducting more outreach and expanding the program to more communities.

PROGRAM AND COUNSELING PARTICIPATION

Most participants reported attending group sessions, but fewer participants reported receiving individual counseling sessions, similar to IRM data analysis. Having completed the program, one participant said they are now seeing a counselor. Other participants noted that they were referred to individual, external counseling sessions but have not attended any. One participant said that, although they were referred to external counseling, they did not attend because they did not have the money or the time while also working.

PARTICIPANT SUCCESSES

Participants identified several successes for the R&R program, primarily around its structure and curriculum.

Many participants described the program as helpful and said it gave them the appropriate tools to recognize and change harmful behavior. One particularly impactful activity was when participants had to write a hypothetical letter to someone they had been in a relationship with and take accountability for what had happened in that relationship. One participant shared,

> After I read the letter, it was like I felt lighter because I was honest about basically my wrongdoing, you know what I mean? Like, it's not easy to admit when you're wrong. It's not easy to apologize when you've done wrong. Even though I didn't say it directly to the person, I did write it to the person, and I read it out loud and that's something, like, to this day I still think about that letter.

Another participant expressed a similar sentiment about the letter-writing assignment, saying that was the moment they realized they needed to change their behavior. One participant said that at times they felt the curriculum did not apply to them because it focused on young adults, but they nonetheless recognized that each session was useful in its own way because "it gave me information that I could share with other people."

Beyond the curriculum, participants found the structure of the program and its facilitation to be crucial successes. One participant appreciated that the program provided a "safe space" to talk about IPV-related issues. Additionally, many stated that the staff who facilitated the sessions were accommodating and understanding regarding individual needs. For instance, one participant said the staff allowed them to complete the program virtually while commuting to work to accommodate their schedule.

Staff representation was identified as another success. Many of the participants spoke at length about one facilitator they believed truly reflected the population that would benefit from this type of program:

> Seeing people from my community also stood out because, you know, mental health and DV [domestic violence] is something that we don't often talk about. It's great to see a Black man running this type of workshop, because you don't see [such] representation when it comes to even talking about mental health.
>
> He also talks about struggles that he went through before. It's nice and powerful to talk to somebody that's been in your position, and [he's] not only showing you ways to grow materially out of the situation, he's also showing you ways to change yourself.

PARTICIPANT PERCEPTIONS ON BEHAVIORAL CHANGE

A majority of participants believed that taking part in the program helped them uncover behaviors they needed to change, understand how trauma was shaping their behavior, and actively work toward changing their behavior. For instance, one participant said that the program was beneficial,

because it illuminated aspects of their behavior they needed to work on, often behaviors they did not know they had a problem with: "It benefited me in the sense that it showed me things about myself that I really didn't even know existed. Things that I needed to work on that I didn't even know I had a problem with."

Many participants reported that the curriculum's focus on understanding and reflecting on trauma helped them recognize the root cause of some of their behaviors. One participant said they learned they have "a lot of defense mechanisms of trauma." A participant also said, " The way we are often stems from our childhood, and how our parents taught us what a relationship looks like."

Many participants, through recognizing harmful behaviors, reported actively worked toward changing those behaviors. One participant shared,

> The first thing I was taught through this program was to pay attention to my stresses. Certain things I didn't even know were stress points for me until it was pointed out. Now I know how to count down when I know I'm going to have a breakdown, whether it's mental, physical, or emotional. The second thing is I've learned that I come up aggressive to people when I talk. Now I try to talk to people with a calm voice. Those are the two things that I've noticed and changed the most within myself.

Participants discussed learning to take accountability in their relationships now that they were able to recognize how they had caused harm. One participant noted that before being in the program, they always had to be right in their relationship. But now they have "started listening more and taking accountability," and apologizing when they are in the wrong.

It benefited me in the sense that it showed me things about myself that I really didn't even know existed. Things that I needed to work on that I didn't even know I had a problem with. —R&R program participant

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PARTICIPANT CHALLENGES

Despite the many positive reflections participants had about the program, they also identified ways that the R&R program could be improved based on current challenges.

Participants identified current levels of program engagement and enrollment as the primary challenge. Some wished there were more than "three to five" other participants in their respective

sessions. They suggested providers focus more on outreach, so more people would learn about the program and hopefully attend. As one participant shared,

> I think it should be known that [providers] need a lot of help with resourcing and outreach. Because if they had a known platform, where a lot of people had access to knowledge of the program being available, it'd be a lot of people signing up compared to just one person telling the next person and it's being a game of telephone.

Many participants recognized the importance of the program and wanted to see it expand and tailored to more demographics, including both older adults and those under 18. One participant shared that "For the young people, they needed it more than I did. And I felt like it was appropriate. But if they were going to change anything, they could have some more resources for older people too."

Though the program currently excludes people under the age of 18, participants believed it was important to reach them, given that "a lot of young kids are going through things, and they can use this as an opportunity to focus on their mental health," as one participant put it. Another shared,

> Maybe taking the R&R alumni to a group to talk about it to recruit kids would be good. I think that will help to reach more youth.... Yeah, I suggest that [there] should be a group for younger folks, which could include the alumni. They have a mentor-mentee program, but they should touch on this starting from younger, because a lot of teenagers go through this.

Beyond recruiting more participants, one person noted that it was difficult not having any physical resources to refer to after the sessions ended. They suggested providers ensure that each participant has access to materials during and after the sessions. This person also believed that 12 weeks was too short and suggested that the program run for longer to allow participants more time to dive into the curriculum.

Some participants felt that, while they appreciated the flexibility and accommodation the program provided, they would have benefited more if the program offered make-up sessions and hosted more in-person sessions. For instance, when one participant experienced technical issues and was unable to attend a session, they said it was "unfair" that the provider did not offer a make-up session. Another participant felt that the program would benefit from holding sessions in person rather than online. While they understood why virtual sessions were in place, they believed that "being involved physically with the human being makes the connection stronger compared to just being on the phone."

Challenges

As expected with any newly developed program, the R&R program experienced several implementation challenges: lower-than-expected enrollment, the need for more outreach to potential participants, better clarity regarding facilitator roles, and some accessibility issues with language. Gathered from interviews with stakeholders, the challenges are presented below.

According to IRM data, during the implementation assessment period from March 2022 to October 2023, the program served only 129 participants across all three providers, a number far lower than expected. The targets set in the RFP state that each provider is to serve 420 participants annually through introductory sessions and around 150 participants annually through multiweek or multihour group programs, counseling, or case management.

As mentioned previously, providers reasoned that the program's exclusion criteria, such as being under the age of 18 and being mandated to participate, played a large role in the low participation. Stakeholders reported that attrition and getting people to stay throughout the 12 weeks posed a challenge, given that they were not mandated to attend (one stakeholder shared that they "don't know what the key is to keep people engaged for 12 weeks"). Stakeholders also mentioned that COVID-19 played a role, as it took away some of the community spaces that providers were to use to implement the program, which limited the ability for participants to attend in person.

Though the program had low participation, one stakeholder reported that "numbers" (that is, the number of people who engage with the program) is not a measure of success; instead, it is the "impact that's actually happening to the people that [we're] working with." They further shared, "I think we stressed about [enrollment] in the beginning but recognizing that you can't help certain things like that, and we just shifted the way we are expecting success and outcomes. Yeah, so I think a lot of success is happening, even if it's not in large numbers."

Complementing this sentiment, participants stated that the program is having a positive impact in their work toward not using violence.

Several stakeholders reported that outreach around and awareness about the program posed great challenges and may have contributed to low enrollment numbers. Providers, funders, and participants stated that it seemed community and government organizations—outside of ENDGBV—were largely unaware of the program. There were several efforts to conduct outreach. For example, providers held community events and reached out to community partners to discuss the program and host circles with staff, and ENDGBV helped convene providers to plan outreach events and publicized the program on its

website and government portals. Still, even with these efforts, every stakeholder expressed that outreach needed improvement. Some went as far as to suggest hiring a person responsible for publicizing the program.

Finally, language and accessibility were major challenges. Providers commented on how the curriculum was "a little too academic." In addition, stakeholders said that the way the program was advertised was inaccessible to an average community member. One shared,

> When you do this work and you have the background and the knowledge, it makes sense to you. However, myself, it was my first time coming into this work, and I was in meetings, I was in workshops, and just getting information with a whole bunch of vocabulary that did not make sense to me…. Obviously, I took it upon myself to learn a lot of things, a lot of roles, how things work. However, when it's a program that's made for your community, this isn't [our] vocabulary.

The stakeholder went on to describe how the average community member may see a disconnect between their harmful actions and IPV, given that "intimate partner violence" is not how many communities describe domestic violence. They further went on to say that the word "harm" is loaded and often confusing when it is used to describe the program to community members.

Furthermore, with 32 percent of the program participants being Hispanic/Latino/Latina/Latine/Latinx, it was challenging for providers to deliver in Spanish a curriculum that was designed in English. Funders and providers hoping to expand the program to more Spanish-speaking participants realized that its current design did not allow for such expansion.

Discussion and Recommendations

In summary, Urban conducted its implementation assessment between March 2022 and October 2023 and found that across the three organizations, program providers served 129 participants; delivered 172 closed group sessions, 27 open group sessions, and 6 introductory sessions; held mostly virtual sessions; and used the curriculum in 87 percent of group sessions.

Data analysis revealed that the program was received well by stakeholders and participants. During an unprecedented global pandemic, New York City staff created a new curriculum for people who wanted to work toward reducing IPV in their lives and recruited dozens of such participants (n=129). Though the three providers implemented the program differently in some aspects, they all used the R&R curriculum, offered counseling sessions, and served mostly young men of color. Providers used the curriculum in 87 percent of their sessions, and they were encouraged and able to modify the content to

meet participants' needs. The program staff relied on peer-led discussions, circles, reflections, and innovative activities to engage with participants.

Urban only spoke to around 9 percent of the total participants, but they overwhelmingly gave positive feedback on the program. During focus groups, they were able to recall certain activities that had a positive impact on them. They mentioned how the program offered them a safe and accessible space. They remarked how positively touched they were seeing someone who had shared lived experience facilitate the program. They expressed how the program helped them uncover behaviors that they needed to change, understand how trauma was shaping their behavior, and actively work toward changing their harmful behaviors.

The program, however, was not without its challenges. The total enrollment was significantly lower than expected. Providers and funders noted that limited outreach and promotion may have led to its low enrollment. They also reported that the language used to administer and describe the program was disconnected from—or not used by—the community it was intended to serve. Finally, providers' internal data systems provided different numbers for program sessions than those that providers shared directly with Urban and those recorded in the facilitator questionnaire.

Despite the challenges, analysis from the program's implementation assessment demonstrates that it is meeting some of its anticipated short- and long-term outcomes. Specifically, the findings imply that the program is making progress toward some of its intended outcomes, such as

- increasing participants' understanding of self,
- increasing participants' knowledge of what abuse is,
- increasing participants' display of self-awareness, and
- increasing participants' social networks among peers.

The program is also reaching people who may not have been engaged by other programs and understanding their needs. In line with recent research, the Respect and Responsibility program for people who engage in IPV in New York City holds promise and should be further evaluated to determine its impact on all anticipated outcomes (Davis et al. 2019; Wong and Bouchard 2020).

To strengthen the program, the Urban research team suggests the following:

- **Ensure that each participant has access to materials during and after sessions.** Some participants stated that they did not have session materials to use after the sessions, although providers reported sending them to participants. Providers should ensure that session materials are, indeed, getting to participants; they may ask participants to confirm receipt of

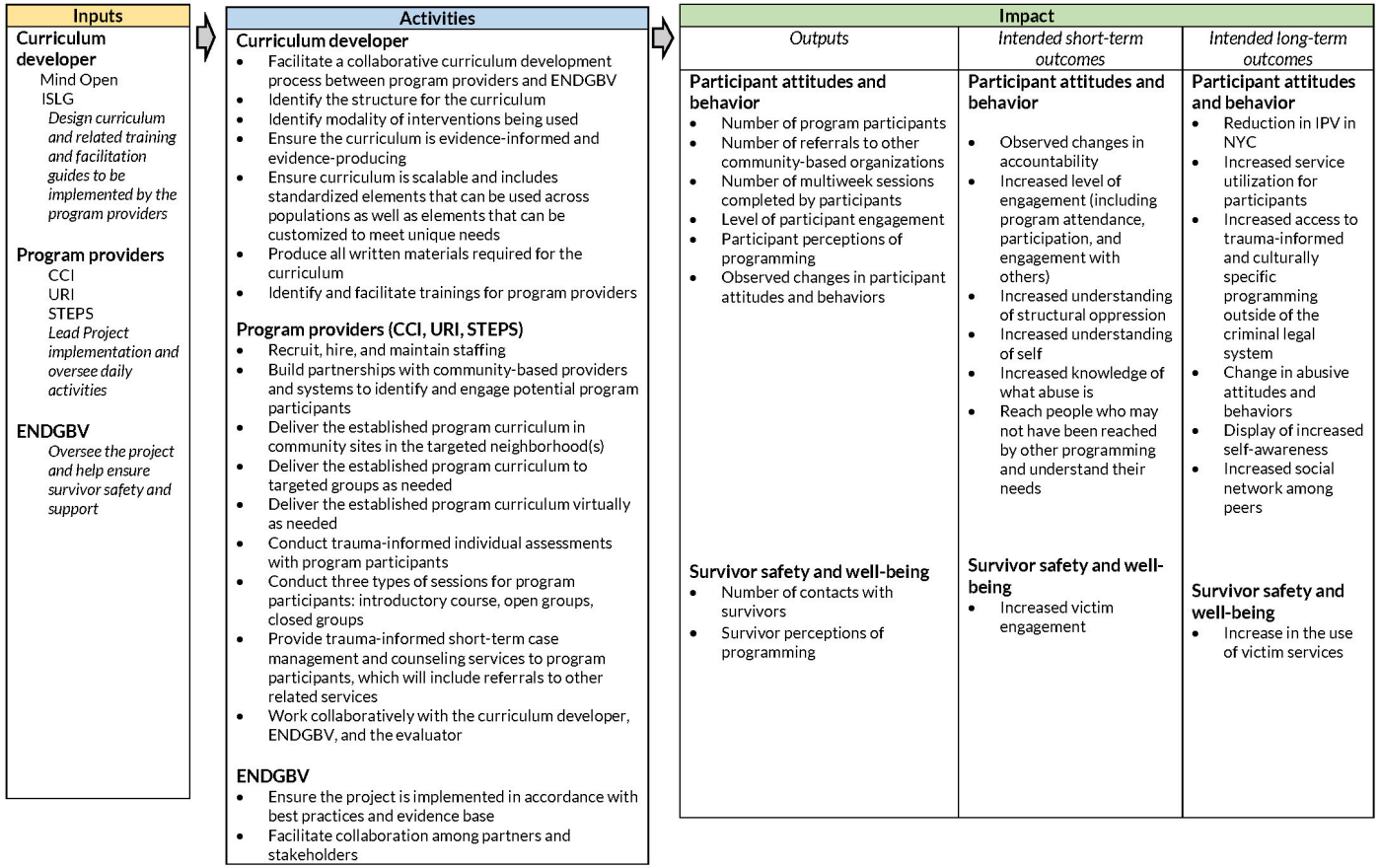
emails or ask during subsequent sessions if participants have used the materials since the last session. Furthermore, providers should inform participants on how to reference the materials when they are not in session.

- **Streamline outreach.** Several stakeholders alluded to having a person responsible for advertising the program. We recommend having one person from the ENDGBV External Affairs team and one person from the ENDGBV Community Initiatives team to work directly with providers regarding outreach, both at the individual provider level and collectively among all providers. In this capacity, ENDGBV staff can guide providers through appropriate outreach strategies and assist them with complementary, rather than competing, referral sources tailored to each provider's strengths. Providers may feel more empowered to market the program if they have people with expertise in communications and community relations who are also familiar with the R&R program working with them.
- **Develop similar programs for people under the age of 18.** Participants and stakeholders pointed out that young people may be interested in such a program. ENDGBV has a forthcoming Respect First initiative, which is both a voluntary and mandated intervention program for young people who cause harm. By working with ENDGBV staff, providers will know where and how to refer young people interested in stopping IPV in their lives.
- **Create a facilitation guide.** Providers had few critiques of the curriculum and used it in 87 percent of the sessions. However, they reported that, at times, the language and activities felt disconnected from their service population. A facilitation guide would instruct providers on ways to modify and add to the curriculum to fit unique populations, such as people of color, people who are LGBTQIA+, and people with lower socioeconomic status.
- **Translate the curriculum and facilitation guide into Spanish.** Stakeholders and funders noted that having the curriculum in Spanish would expand reach and accessibility. It would help facilitators deliver content in Spanish, encourage Spanish-speaking participants to join, establish better connections with Hispanic/Latino/Latina/Latine/Latinx community organizations and members, and provide opportunity for organizations that typically deliver Spanish intervention programs to become part of the R&R program.
- **Consider extending the length of the program.** Most mandated programs for people who cause harm to their intimate partners are at least 24 weeks (Flasch et al. 2021). By contrast, the nonmandated R&R program is 12 weeks, which may not be sufficient time for participants to work toward intended outcomes.
- **Refine data reporting practices for providers.** As demonstrated by the discrepancies in figures reported by providers, in the IRM, and the facilitator questionnaire, providers may benefit from modifying data reporting practices. Such modification can take the form of relying on providers' previously established systems or providing quarterly trainings on using the IRM to ensure consistency.

- **Evaluate the program.** To analyze whether the R&R program meets its anticipated short- and long-term outcomes, external researchers should evaluate the program. Such evaluation can include participant surveys, interviews, and/or focus groups with participants' family members, among other data-collection activities.

Appendix. R&R Project Logic Model

Goal: Establish an evidence-base and ensure a program design that maintains a focus on survivor safety and survivors' experiences while being tailored to the needs of those who cause harm to optimize voluntary engagement in the program.



Assumptions: 1. Steady source of funding; 2. Buy-in from city stakeholders; 3. Culture that encourages programming and services outside the criminal legal system.

Source: Urban Institute.

Notes: CCI = Center for Court Innovation (now the Center for Justice Innovation). . ENDGBV = New York City Mayor's Office to End Domestic and Gender-Based Violence. ISLG = Institute for State and Local Governance. IPV = intimate partner violence. URI = Urban Resource Institute .

Notes

[1] "Current Initiatives," NYC Mayor's Office to End Domestic and Gender-Based Violence, accessed December 12, 2023, https://www.nyc.gov/site/ocdv/programs/initiatives.page.

[2] For the other two goals , Urban established a foundation for future evaluation of the R&R program by creating and refining the program's logic model depicting its inputs, activities, outputs, and anticipated outcomes; and, in September 2022, Erica Henderson and Storm Ervin published an internal curriculum development memorandum that included findings from interviews and curriculum planning meetings with providers, funders, the curriculum developer, and associated organizations. Erica Henderson and Storm Ervin, "Respect and Responsibility Curriculum Development," internal memo, Urban Institute, 2022.

[3] MindOpen Learning Strategies provides engaging, transformative learning experiences for individuals, groups, and organizations working toward social justice goals. "About," MindOpen Learning Strategies, accessed December 13, 2023, https://www.mindopenlearning.com/about.

[4] The New York City Crisis Management System involves a network of 21 nonprofit organizations that employ credible messengers who mediate neighborhood conflicts and connect individuals at high risk for street violence to appropriate services. "Interventions," New York City Office to Prevent Gun Violence, accessed December 13, 2023, https://www.nyc.gov/site/peacenyc/interventions/crisis-management.page.

[5] Urban Resource Institute was founded in 1980, and it is the nation's largest provider of domestic violence shelter and services. "History," Urban Resource Institute, accessed December 13, 2023, https://urinyc.org/history/.

[6] There may have been questionnaires completed by each facilitator who co-facilitated the same session.

[7] Because implementation differed across the three providers, Urban identifies them as providers A, B, and C in its findings.

[8] Providers' implementation of introductory sessions varied, as described later. Some kept the sessions separate, bringing the total program to 13 weeks, and others began to incorporate them into the 12-week program.

[9] Whereas the facilitator questionnaire reported that there were 205 virtual sessions and 32 in-person sessions, IRM data revealed that there were over 385 sessions. This discrepancy is likely due to facilitators not completing the questionnaire for every session. Moreover, whereas the IRM data reported over 385 closed group sessions, 82 open group sessions, and 7 introductory sessions, providers' internal data show different numbers in each category. This discrepancy is likely due to inconsistencies in IRM data entry, or other data entry issues, and is present when comparing the number of session types.

[10] Whereas IRM data reported 97 intake sessions, 186 counseling sessions, and 115 instances of case management services, in their internal data, two providers reported 129 intake sessions, 192 counseling sessions, and 174 instances of case management, and the other provider reported providing case management services to 13 people and did not record the number of times they provided this service. Again, these differences are most likely due to data entry issues.

[11] Only two providers reported providing open group sessions and two providers reported providing introductory sessions.

[12] This provider did not record the number of times they provided case management services to the 13 people.

[13] One participant who identified their race as "other" did not give provider information.

[14] To learn more about the Family Peace Initiative and its training programs, visit https://www.familypeaceinitiative.com/.

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