

Opportunities to Address and Prevent Intimate Partner Violence among Children, Youth, and Families through California's Behavioral Health Initiatives

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List of Abbreviations

ACEs	Adverse Childhood Experiences
BH	behavioral health
CaAIM	California Advancing and Innovating through Medi-Cal
CalHHS	California Health and Human Services Agency
CalMHSA	California Mental Health Services Authority
CBO	community-based organization
CHW	community health worker
CUES	confidentiality, universal education, empowerment, and support
CYBHI	California Youth Behavioral Health Initiative
DHCS	California Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
ECM	Enhanced Care Management
HCAI	Department of Health Care Access and Information
IPV	intimate partner violence
LEA	Local Educational Agencies
MCP	managed care plan
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
NSMHS	Non-Specialty Mental Health Service
PMPM	per member per month
SDOH	social determinants of health
SHC	school health center
SMHS	Specialty Mental Health Service
SPA	State Plan Amendment
TA	technical assistance
UE	universal education
UCSF-CADP	University of California San Francisco Center for Advancing Dyadic Care in Pediatrics

Executive Summary

Intimate partner violence (IPV) is a widespread, multigenerational public health issue in California that requires coordinated and integrated systemic intervention. The state’s recent efforts to expand and reinforce the existing behavioral health (BH) system present an opportunity to adopt or broaden evidence-informed strategies to address IPV for children, youth, and their families.

Experience of or exposure to IPV often begins in childhood and can lead to or exacerbate health risk factors, such as challenges with mental health, BH, and maladaptive coping strategies such as substance use. If unaddressed, these challenges can also extend into adulthood and contribute to multigenerational cycles of violence. California is creating a new BH infrastructure and expanding existing BH services to children, youth, and their families through initiatives such as:

- / Those funded by the Children and Youth Behavioral Health Initiative (CYBHI) and the Mental Health Services Oversight and Accountability Commission (MHSOAC),
- / Efforts to strengthen services already covered by Medi-Cal, such as the family therapy benefit and California Advancing and Innovating Medi-Cal (CalAIM) enhanced care management (ECM), and
- / Initiatives to expand the workforce that provides behavioral health services to include peer supports and community health workers/*promotores* (CHWs).

This policy brief describes opportunities and presents recommendations for the California Health and Human Services Agency (CalHHS), the Department of Health Care Services (DHCS), other state government agencies, and managed care plans (MCPs), to address IPV within California’s new and established BH initiatives. Recommendations emphasize the importance of using evidence-informed practices and collaborating with IPV service and BH providers, and other community-based organizations (CBOs) (summary of recommendations in Table 1). The policy brief also provides actionable strategies for each recommendation (Tables 2-4 in Section II). See Appendix A for our methods and Appendix B for a list of California’s BH initiatives that we examined.

Table 1. Recommendations to address IPV through California’s BH initiatives

Recommendations	Actors
Provide IPV guidance and training to BH providers	
Require MCPs to fund training to BH providers on power dynamics in violent relationships; the impact of IPV on the health of children, youth, and their caregivers; prevention and response strategies; and building partnerships with local IPV providers for IPV prevention and intervention. BH organizations and MCPs should partner with and fund IPV service providers and advocacy organizations to provide training.	DHCS and MCPs
Protect the safety and security of IPV survivors by providing guidance and training to all providers on trauma-informed documentation of survivor information, confidentiality, privacy, and mandated reporting requirements.	DHCS and MCPs
Ensure the expanding health care workforce (for example, CHW, peer support specialists, doulas) has the knowledge and skills to identify and address IPV.	DHCS, HCAI, CalMHSA, and MCPs

Opportunities to Address and Prevent Intimate Partner Violence among Children, Youth, and Families through California’s Behavioral Health Initiatives

Recommendations	Actors
Continue and expand guidance and TA to MCPs and providers for new benefits like the dyadic services benefit, which offers considerable opportunity to provide IPV prevention, early intervention, and support to survivors.	DHCS
Promote awareness of IPV responsibilities, opportunities, and services	
Specifically name survivor-centered care, in addition to trauma-informed care and practices, in new BH benefits and services and in MCP contracts.	DHCS and MCPs
Encourage and incentivize IPV service providers to partner with BH providers to develop prevention and intervention programs identifying and addressing IPV using grant funding available in BH initiatives.	DHCS, MHSOAC, and other grant-administering agencies
Educate communities on the dynamics of IPV and services and supports that are available to them.	CalHHS, MCPs, and grant-administering agencies
Publicize new benefits and services like the dyadic services benefit, the expanded family benefit, and school-linked BH services, so that providers in BH, primary care, and CBOs are aware of them.	DHCS
Design BH programs and benefits with IPV in mind	
Require and fund more culturally and linguistically accessible case management and care coordination to holistically identify and address IPV-related needs of children, youth, and their families.	DHCS and MCPs
Encourage efforts that aim to expand BH services to incorporate IPV education, assessment, and response.	DHCS and other grant-administering agencies
Include community advisory groups to inform, guide, and support the inclusion of IPV prevention and early intervention services in programs to expand the BH system.	DHCS, MHSOAC, and MCPs

BH = behavioral health; CalHHS = California Health and Human Services Agency; CalMHSA = California Mental Health Services Authority; CBO = community-based organization; CHW = community health worker; DHCS = Department of Health Care Services; HCAI = Department of Health Care Access and Information; IPV = intimate partner violence; MCP = managed care plan; MHSOAC = Mental Health Services Oversight and Accountability Commission; TA = technical assistance.

I. Introduction

A. Impact of IPV on mental health among children and youth

California's efforts to expand and strengthen the state's behavioral health (BH) system present an opportunity for health system and community partners to adopt or promote evidence-informed strategies to prevent, identify, and address intimate partner violence (IPV) for children, youth, and their families. The purpose of this policy brief is to highlight evidence-informed strategies and opportunities to integrate IPV services into BH services in California to improve care, safety, and mental health.

IPV is a pervasive public health crisis, both nationally and in California. On May 25, 2023, the White House acknowledged the extent of the impact of IPV on public safety and public health with its release of the first-ever U.S. National Plan to End Gender-Based Violence.¹ Among California residents, 35 percent of women and 31 percent of men report experiencing violence from their partner at some point in their lives.² IPV adversely affects children and youth, either through direct experience of IPV or exposure to it. Nationally, young adults (ages 18 to 24) have the highest prevalence of exposure to IPV.³ More than one in six children and youth (ages 1 month to 17 years) have witnessed IPV in their lifetime; and in older youth (ages 14 to 17), almost one in three have witnessed IPV.⁴

Experiencing or witnessing IPV can lead to mental health challenges or contribute to existing mental or BH conditions. Child or adolescent exposure to IPV is associated with BH challenges including anxiety and depression, behaviors such as aggression and attention problems, and negative outcomes such as suicidality.^{5,6,7} Without interventions, these adverse effects can extend into adulthood and increase risks of mental health diagnoses, suicidal ideation, social dysfunction, and impaired parenting. The effects of IPV on children and adolescents can also contribute to multigenerational cycles of violence. Childhood exposure to IPV is associated with perpetration of physical violence as an adult.⁸ Childhood exposure of IPV can correlate with child maltreatment⁹ and poly-victimization, which is defined as repeated experiences of violence across an individual's lifetime.¹⁰ These lifelong and multigenerational effects underscore the importance of IPV prevention and interventions for children and youth exposed to IPV, including approaches to keep non-offending caregivers and youth together to promote safety and healing.^{11,12}

California is developing and expanding BH supports and services to children, youth, and their families through efforts such as those that comprise the [CYBHI](#), efforts to enhance Medi-Cal covered services such as the [family therapy benefit](#), [CalAIM ECM](#), initiatives to expand the BH workforce including peer supports and CHWs, and county-level activities directed and funded by the [MHSOAC](#)ⁱ (Appendix B).

We conducted an environmental scan and interviewed key informants to identify opportunities to assess and address IPV and interrupt the multigenerational cycle of violence through these BH

ⁱ On October 12, 2023, California governor Newsom signed two bills—[Senate Bill 326 and Assembly Bill 531](#)—that will modernize the Behavioral Health Services Act and change MHSOAC's administrative and funding authorities. Californians will vote on this package, collectively known as Proposition 1, in March 2024. Opportunities to address IPV in future MHSOAC's efforts remain to be seen, after the vote and the proposed restructuring.

programs and activities. (See Appendix A for a description of our approach.) This policy brief describes opportunities for CalHHS, DHCS, other state government agencies, and MCPs to address IPV within these BH initiatives, emphasizing those with the greatest prospect of partnership between IPV service organizations and other CBOs and BH providers. Section I.B offers background and context for California's BH initiatives. Sections II.A through II.C provides recommendations and actionable strategies. See Appendix C for a list of key terms.

B. California context

Many initiatives in California seek to enhance BH for children, youth, and their families by (1) expanding coverage of BH benefits, (2) building BH infrastructure and capacity, (3) building public awareness of BH concerns and resources, and (4) developing the BH workforce (Appendix B). Some broad initiatives like CYBHI and MHSOAC have a number of efforts in multiple areas of activity. For example, two CYBHI activities seek to expand coverage for BH benefits: Enhanced Medi-Cal Benefits – [Dyadic Service](#) and [Statewide Multi-Payer School-Linked Fee Schedule for BH services](#). Other activities of CYBHI offer grant funds for expanding BH programs and services—examples include: [Scaling Evidence-Based and Community-Defined Evidence Practices](#) and [School-Linked Partnership and Capacity Grants](#). Appendix B offers additional details on these and other activities nested within larger BH initiatives.

In examining opportunities to assess and address IPV in California's BH initiatives, we sought to identify recommendations for current and future efforts in the state. Agencies like the DHCS that oversee programs currently in design and implementation phases could consider these recommendations as part of rapid-cycle improvement processes. Programs that have already been implemented, as is the case for some of these activities, offer lessons for addressing IPV in future BH initiatives. One future initiative is a proposed amendment of the CalAIM Section 1115 demonstration, which DHCS submitted on October 20, 2023, to the Centers for Medicare & Medicaid Services (CMS), requesting a new demonstration called the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT).¹³ The new demonstration seeks to expand the continuum of community-based BH services for Medi-Cal members living with serious mental illness and serious emotional disturbance. In addition, on October 12, 2023, Governor Newsom proposed the California Mental Health Movement, a multi-year plan that includes more than \$28 billion to expand BH treatment and residential housing, increase access to mental health services for all Californians, build the health care workforce, and support and serve children.¹⁴ As CalHHS develops and implements these new initiatives, it should consider recommendations in this policy brief to address IPV services for children, youth, and families in a way that protects their privacy, confidentiality, and safety.

II. Recommendations to Address IPV Through California's BH Initiatives

As California invests in efforts to expand and strengthen the BH system for children, youth, and families, DHCS, MHSOAC, other grant-administering agencies, MCPs, and community partners must look for opportunities to better identify and address IPV in their BH initiatives. Based on our review of the literature and conversations with key informants, we identified 11 recommendations for

addressing IPV in current and future BH initiatives in California. The recommendations fall into the three primary areas: (A) providing IPV guidance and training to BH providers; (B) promoting awareness of IPV responsibilities, opportunities, and services; and (C) designing programs and benefits with IPV in mind. Sections II.A, II.B, and II.C each include a table summarizing recommendations and actionable strategies for addressing IPV, followed by narrative detail and examples. Section II.D offers three additional recommendations for changes to the overarching BH system within which these initiatives are implemented.

A. Provide IPV guidance and training to BH providers

Explicit training on IPV will enable BH providers to offer assistance that is helpful, safe, and survivor-centered to the people they serve. Trauma-informed training that focuses on IPV power dynamics, its health impacts, and the special considerations for documentation of services and mandated reporting will equip California’s existing and growing BH workforce to identify and appropriately address IPV. This section describes recommendations for DHCS, MCPs, and other agencies about providing IPV guidance and training to BH providers (audience for the recommendation is in brackets). It also provides the evidence supporting these recommendations and actionable strategies to implement them (Table 2).

Table 2. High-level recommendations and actionable strategies to provide IPV guidance and training to BH providers

Recommendations	Actionable strategies
<p>1. Require MCPs to fund training to BH providers on power dynamics in violent relationships; the impact of IPV on the health of children, youth, and their caregivers; prevention and response strategies; and building partnerships with local IPV providers for IPV prevention and intervention. BH provider organizations and MCPs should partner with and fund IPV service providers and advocacy organizations to provide training [DHCS and MCPs].</p>	<ul style="list-style-type: none"> • DHCS should require MCPs to partner with and fund IPV service providers and advocacy organizations to train BH providers about IPV. • MCPs should partner with and fund IPV service providers and advocacy organizations to: <ul style="list-style-type: none"> – Provide specialized training on IPV that is trauma-informed and culturally responsive to BH providers so they understand their role in supporting IPV survivors. Training should include topics such as coercive control, tactics of IPV, power dynamics, and gender-based violence. – Develop meaningful partnerships between BH providers and local IPV service providers and other CBOs delivering services to support survivor health and social needs (such as housing, transportation, or legal services).

Recommendations	Actionable strategies
<p>2. Protect the safety and security of IPV survivors by providing guidance and training to all providers on trauma-informed documentation of survivor information, confidentiality, and privacy. Particular attention should be given to helping providers understand which circumstances they are not mandated to report and how to communicate with survivors when they are obligated to report [DHCS and MCPs].</p>	<ul style="list-style-type: none"> MCPs should partner with IPV advocacy organizations to develop guidance for providers about when and how to communicate with survivors and record IPV in medical records. They should also adopt practices to protect survivor confidentiality and safety in MCP communications and documentation of services (for example, explanation of benefits). In the case of new benefits, MCPs should work with BH providers to guide documentation of survivor information. DHCS and MCPs should partner with, and fund, IPV service providers and advocacy organizations to establish clear guidance and protocols for providers on state policies for mandated reporting, and how they apply to IPV. DHCS and MCPs should ensure providers are adequately trained on all mandated reporting policies.
<p>3. Ensure the expanding health care workforce (for example, CHWs, peer support specialists, and doulas) has the knowledge and skills to identify and address IPV [DHCS, HCAI, CalMHSA, and MCPs].</p>	<ul style="list-style-type: none"> DHCS should partner with the Department of Health Care Access and Information (HCAI), California Mental Health Services Authority (CalMHSA), and IPV experts to develop requirements for educating and training the expanding health care workforce—including peer support specialists, CHWs, and doulas—to understand, screen for, prevent, and address IPV. These providers should receive training on survivor-centered care, trauma-informed documentation of survivor information, confidentiality, privacy, mandated reporting, and community-based resources for survivors. HCAI and CalMHSA should include IPV training in certification requirements for the expanding health care workforce. DHCS should require that MCPs ensure the expanding workforce receives IPV training.
<p>4. Continue and expand guidance and TA to MCPs and providers to help implement new benefits like the dyadic services benefit, which offers considerable opportunity to provide IPV prevention and early intervention and support to survivors [DHCS].</p>	<ul style="list-style-type: none"> DHCS could distribute best practices and provide more widespread implementation TA for new benefits like the dyadic services benefit, similar to what DHCS already provides via the UCSF Center for Advancing Dyadic Care in Pediatrics. TA for new benefits could incorporate strategies for preventing, identifying, and addressing IPV. DHCS could also expand the reach of TA on new benefits by developing materials to support implementation and creating dissemination channels to diffuse learning.

BH = behavioral health; CBO = community-based organization; DHCS = Department of Health Care Services; IPV = intimate partner violence; MCP = managed care plan; TA = technical assistance.

Recommendation 1. Require MCPs to fund training to BH providers on power dynamics in violent relationships; the impact of IPV on the health of children, youth, and their caregivers; prevention and response strategies; and building partnerships with local IPV providers for IPV prevention and intervention. [DHCS, MCPs]

BH organizations and MCPs should partner with and fund IPV service providers and advocacy organizations to provide training. Providers should receive training on topics such as coercive control, tactics of IPV, power dynamics, and gender-based violence.¹⁵ Training should give providers the skills and resources to promote prevention and to intervene before, during, or after an



“There is an assumption that all BH providers understand IPV because of their profession, which is a dangerous assumption.”

—Director of IPV advocacy organization

IPV crisis in a way that empowers, rather than pathologizes survivors.¹⁶ In addition to understanding their role in supporting IPV survivors and their needs, BH providers should receive information about local IPV service providers to help connect survivors to the resources they need, such as housing, legal aid, and other services that address social determinants of health (SDOH).¹⁷

Provider training on the characteristics of IPV, the implications of IPV for health outcomes, and community-based supports would add value to BH programs or benefits—both those that are in development as well as those already in implementation, such as MHSOAC's [allcove Youth Drop-in Centers](#) and CYBHI's School-Linked Partnership and Capacity Grants.

Rationale. Trauma-informed care is a broad framework that informs how providers should understand trauma, however, not all trauma-informed trainings incorporate explicit IPV training. Without explicit training on IPV, BH providers may find it challenging to apply practical aspects of trauma-informed care when delivering services to survivors and those at risk for IPV.^{18,19,20}

Several BH providers we interviewed noted that training in trauma-informed care does not automatically equip BH providers to identify or address IPV with survivors. According to a director of an IPV advocacy organization, without an understanding of how to ensure safety and security for survivors, BH providers could create an environment that increases risk of harm and violence for survivors. IPV service providers and advocates noted that BH providers should receive ongoing training about IPV prevention and intervention.

- **Strategy. DHCS should require MCPs to partner with and fund IPV service providers and advocacy organizations to provide specialized training on IPV to BH providers so they understand their role in supporting IPV survivors.** For example, Community Solutions provides trainings on topics such as the intersections of gender-based violence and trauma-informed care.^{21,22} Community Solutions trainings include a 70-hour course on IPV and trauma for sexual assault, domestic violence, and sex trafficking advocates, and a 20-hour IPV training for CHWs.²³ The California Partnership to End Domestic Violence has also created a 40-hour domestic violence training in conjunction with the California Office of Emergency Services for domestic violence counselors.²⁴ According to California Evidence Code Section §1037.1(a)(1), the state requires that domestic violence counselors receive a 40-hour certification training provided by local IPV service providers and other community-based organizations. The content and length of these trainings could be adapted to better meet the knowledge needs of BH providers. MCPs could fund IPV service providers and advocacy organizations to adapt trainings and deliver them to BH providers.



“Unfortunately, we still see a lot of victim blaming. It’s about understanding that we’re not pathologizing victims, we want to support survivors in a way that is empowerment-based, nonjudgmental, and survivor-centered.”

—Director of CBO that provides IPV and BH services

Recommendation 2. Protect the safety and security of IPV survivors by providing guidance and training to all providers on trauma-informed documentation of survivor information, confidentiality, privacy, and mandated reporting. [DHCS and MCPs]

Providers must receive training on key protections for survivors, such as:²⁵

- / Robust and informed patient consent about any reporting requirements and sharing of health care data
- / Patient control over how their data are shared and with whom (for example, how the patient wants to be contacted about results)
- / Transparency with the patient about who has access to their data, and when their data are shared
- / Enforceable penalties for violations of privacy

Guidance and training, provided in partnership with IPV advocacy organizations, would help MCPs and providers implementing new BH benefits and programs to develop administrative processes to protect IPV survivors.

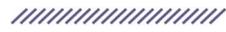
Rationale. Survivors could be at risk for experiencing harm from a partner following an IPV disclosure or after receiving a confidential service. Therefore, all providers must be aware of special considerations regarding documentation of services and reporting requirements when serving survivors and their families.

- **Strategy. MCPs should partner with IPV advocacy organizations to develop guidance for providers about when and how to communicate with survivors and record IPV in medical records to protect survivors.** MCPs should adopt practices to protect survivor confidentiality and safety in their communications and documentation of services (for example, explanation of benefits). In the case of new benefits, MCPs should work with BH providers to guide documentation of survivor information.

Under the 21st Century Cures Act (Cures Act), clinicians are required to make medical notes available to patients.²⁶ In the case of dyadic services where a child's parent or guardian is experiencing IPV, an open note can become a safety risk if the person who has used harm can access the child's chart. There are steps clinicians can take to block and protect notes from patient access and there are exceptions for IPV within the Cures Act that allow providers to do so. A resource on privacy principles for protecting survivors of IPV and exceptions to the Cures Act is available at [Health Partners on IPV + Exploitation](#). The University of California San Francisco Center for Advancing Dyadic Care in Pediatrics (UCSF-CADP), which provides TA to pediatric clinics implementing the new dyadic services benefit, has developed guidance for safely documenting IPV disclosures, which it is developing into a public resource.

- **Strategy. DHCS and MCPs should partner with and fund IPV advocacy organizations to establish clear provider guidance and protocols for applying state mandated reporting policies to IPV in new BH benefits and programs for children and youth.** DHCS and MCPs should ensure providers are adequately trained on all mandated reporting policies. Providers may need clarity on

when it is appropriate to report violence, and to whom a report should be made (for example, a child welfare agency, or law enforcement). For example, when a caregiver discloses IPV during a well-child visit, the pediatrician may be unclear if this qualifies as a mandated report. Historically, different interpretations of mandated reporting laws have resulted in the removal of a child from a home, or punitive treatment towards survivors, which deter survivors from seeking BH care.^{27,28,29} A California county [council published a memo](#) in 2003 to provide social workers with more guidance and clarity about when to make a mandated report. The memo clarified that exposure to domestic violence (for example, when a child witnesses IPV) does not necessitate a mandated report.³⁰



"The fact that a child's parent or guardian has been the victim of domestic violence is not in and of itself a sufficient basis for reporting suspected child abuse or neglect. Further, a child's exposure to a domestic violence incident in and of itself is not sufficient basis for reporting suspected abuse or neglect."

—Council guidance on mandated reporting

Futures Without Violence, an IPV advocacy organization, created a [resource on mandated reporting laws](#) for California practitioners that includes common questions and answers on mandated reporting requirements for adults; suggested mandated reporting procedures; a summary of mandated reporting laws in California; and relevant practices to increase informed consent opportunities for survivors.^{31,ii} Creating similar guidance for children and youth would help pediatric primary care providers and school BH providers, for example, understand mandating reporting requirements in their care settings.



"Survivors need to be made aware who is a mandated reporter and what the process for mandated reporting looks like so there can be safety around mandated reporting."

—Director of CBO that provides IPV and BH services

Providers should frequently review mandated reporting guidelines with patients to increase informed consent, patient autonomy, and trust. DHCS, other grant-administering agencies, and MCPs should partner with and fund IPV service providers and advocacy organizations to develop best practices and train providers on communicating with patients about the limitations of patient confidentiality and when a mandated report will be made.

Recommendation 3. Ensure the expanding health care workforce has the knowledge and skills to identify and address IPV. [DHCS, HCAI, and MCPs]

Rationale. California is expanding its health care workforce and Medi-Cal services, offering new avenues by which Californians can access BH services through extended postpartum care,³² the doula services benefit,³³ the CHW benefit,³⁴ and the peer support specialist benefit.^{35,36} As California expands its health care workforce, it is imperative to disseminate high-quality IPV training and

ⁱⁱ Advocacy organizations are currently advancing a [policy debate](#) on the impact of medical mandatory reporting, with the hopes of changing mandated reporting laws.

resources to providers so they are equipped to promote IPV prevention and work with survivors in a myriad of settings.

- **Strategy.** DHCS should partner with HCAI, CalMHSA, and IPV experts to develop requirements for educating and training the expanding health care workforce—including peer support specialists, CHWs, and doulas—so they understand, prevent, identify, and address IPV. For example, CalMHSA should require training in IPV prevention and intervention in the curriculum for peer support specialist certification. In addition, DHCS should require that MCPs ensure the expanding health care workforce receives training on survivor-centered care, trauma-informed documentation of survivor information, confidentiality, privacy, mandated reporting, and community-based resources for survivors. The National Plan to End Gender-Based Violence highlights the necessity of expanding the availability of specialists who are trained in trauma-informed best practices for IPV response and suggests providing financial assistance or other incentives for those who are interested, including professionals and survivor advocates.³⁷

Recommendation 4. Continue to expand guidance and TA to MCPs and providers to help implement new benefits like the dyadic services benefit, which offers considerable opportunity to provide IPV prevention, early intervention, and support to survivors. [DHCS]

Rationale. Implementation of new benefits takes time. Clarity among MCPs and providers about the practical details of implementation—such as eligibility of providers that can bill, and new practice workflows and billing procedures—can augment the process. For example, TA may help Federally Qualified Health Centers (FQHCs) and other agencies that are providing dyadic services through established HealthySteps programs, but who are not billing Medi-Cal because of confusion about which providers can allowably bill.



“Switching on the benefit from the payer side is easy but true implementation requires more technical assistance and information to support development of provider networks and workflows.”

—MCP Chief Medical Officer

- **Strategy.** DHCS should distribute best practices and provide more widespread TA to help MCPs and providers implement new benefits, similar to what UCSF-CADP provides for the dyadic services benefit (Exhibit 1). TA for new benefits could incorporate strategies for preventing, identifying, and addressing IPV.

To improve IPV services, TA should address new workflows and communication channels that providers need to support the continuum of care for IPV survivors. Providers and MCPs must develop new workflows to help IPV survivors transition between specialty MH services, non-specialty MH services, and services to address SDOH as survivors’ needs change. For example, in the initial phase of assessing for IPV, a survivor’s most immediate needs may include linguistically appropriate BH crisis intervention and connection to safe and affordable housing. However, once a BH crisis has been addressed and housing has been secured, a survivor may need connection to an IPV advocate to access childcare to enable the survivor to continue receiving BH care.

To help streamline implementation, TA should provide clarity to providers and MCPs on:

- / Importance of the benefits
- / Who is eligible to receive benefits
- / Possible partnerships for providing newly covered services
- / New workflows and communication channels

Organizations involved in TA activities to convene partners and coordinate implementation pathways must be trusted organizations that can maintain neutrality and apply their knowledge of the relevant partners to foster collaboration.

Exhibit 1. Case study: UCSF-CADP comprehensive training and TA for implementation of dyadic services

UCSF-CADP provides a TA program to support implementation of the dyadic services benefit, funded by First 5ⁱⁱⁱ and MCP partnerships, UCLA-UCSF ACEs Aware Family Resilience Network (UCAAN), Genetech, among other sources. The program aims to create community partnerships among health plans, county health systems, First 5 organizations, and pediatric or family clinics to work on implementing the dyadic services benefit. The TA program includes the following activities:³⁸

- Engages and onboards leaders in partner organizations
- Conducts a landscape assessment and supports selection of appropriate dyadic models (for example, HealthySteps, DULCEiv)
- Works with clinics to hire and train pediatric and family medicine clinicians, develop practice workflow, establish credentialing with MCPs for non-specialty MH behavioral health services, and implement the dyadic services benefit model
- Supports development of quality improvement and informatics (for example, data tracking, reporting, progress monitoring)
- Supports clinic and MCPs collaboration to build the infrastructure to bill for dyadic services
- Supports evaluation and sustainability planning

To provide TA, UCSF-CADP offers site-specific coaching, TA resource development, and a learning community. It also provides support through a combination of quarterly cohort-based learning collaboratives, quarterly dyadic trainings, and monthly site visits. These activities intend to help pediatric, or family clinics do the following:

- Communicate with health plans to understand their contracts and which dyadic services are reimbursable
- Develop communication channels through reflective consultations among clinicians to help bridge the separation between BH providers and health care providers that may challenge collaboration

- **Strategy. DHCS should expand the reach of TA for new benefits by funding the development of implementation materials and dissemination channels to help diffuse learning.** To assist other MCPs and providers seeking to implement new benefits like the dyadic services benefit, DHCS should make informational materials widely available. These materials could include guidance for

ⁱⁱⁱ Providers, advocacy organizations, county commissions dedicated to supporting early education, health programs, services, and resources for young children (prenatal through age 5) and their families.

^{iv} Program models for dyadic services can be found at <https://dyadiccare.ucsf.edu/intro>.

providers (for example, on documenting IPV in medical notes) and information about new workflows and communication channels that have been developed to improve connection and transitions between BH service systems.

B. Promote awareness of IPV responsibilities, opportunities, and services

Public health systems, the providers within those systems, and community members should have access to information and education opportunities about best practices for preventing, identifying, and addressing IPV. This section describes recommendations for DHCS, MCPs, MHSOAC, and other grant-administering agencies about promoting awareness of IPV responsibilities, opportunities for education and outreach, and services. It also provides the evidence supporting these recommendations and actionable strategies to implement them (see Table 3).

Table 3. High-level recommendations and actionable strategies to promote awareness of IPV responsibilities, opportunities, and services for children, youth, and their families in California’s BH initiatives

Recommendations	Actionable strategies
5. Specifically name survivor-centered care, along with trauma-informed care and practices, in new BH benefits and services and in MCP contracts [DHCS and MCPs].	<ul style="list-style-type: none"> DHCS should include addressing IPV in new Medi-Cal benefits and policy guides to MCPs about those benefits. MCPs should include language in their contracts about addressing IPV.
6. Encourage and incentivize IPV service providers to partner with BH providers to develop prevention and intervention programs identifying and addressing IPV using grant funding available in BH initiatives [DHCS, MHSOAC, and other grant-administering agencies].	<ul style="list-style-type: none"> DHCS, MHSOAC, and other grant-administering agencies should include IPV in the design of start-up grants such as School-Linked Partnership and Capacity Grants. They should partner with IPV services organizations to design the IPV aspect of these grants and encourage schools to partner with IPV service providers to create school-based education programs. DHCS, MHSOAC, and other grant-administering agencies should engage IPV advocacy organizations and fund them to help publicize grant opportunities for IPV service providers to partner with BH providers. Examples of grant opportunities include CYBHI’s Scaling Evidence-Based and Community-Defined Practices, CYBHI’s School-Linked Partnership and Capacity Grants, and MHSOAC’s Innovation Incubator.
7. Educate communities on the dynamics of IPV and services and supports that are available to them [CalHHS, MCPs, and grant-administering agencies].	<ul style="list-style-type: none"> CalHHS, MCPs, and grant-administering agencies should include trusted community workers—like CHWs/<i>promotores</i>, peers, wellness coaches, doulas—to educate the community about new BH resources and services and to provide culturally and linguistically appropriate care.
8. Publicize new BH benefits and services like the dyadic services benefit, the expanded family benefit, and school-linked BH services so that IPV service providers and other CBOs are aware of them [DHCS].	<ul style="list-style-type: none"> DHCS and MCPs should partner with IPV advocacy organizations to communicate with IPV service providers about new BH benefits and services—like the dyadic services benefit, the expanded family benefit, and the multi-payer fee schedule for school-linked BH services—and how to deliver and bill for them.

BH = behavioral health; CalHHS = California Health and Human Services Agency; CBO = community-based organization; CHW = community health worker; DHCS = Department of Health Care Services; IPV = intimate partner violence; MCP = managed care plan; MHSOAC = Mental Health Services Oversight and Accountability Commission.

Recommendation 5. Specifically name survivor-centered care, in addition to trauma-informed care and practices, in new benefits like ECM and CYBHI’s Multi-Payer School-Linked Fee Schedule for BH services, and in MCP contracts. [DHCS and MCPs]

Rationale. Defining what survivor-centered care should entail in Medi-Cal benefits adds another mechanism to promote coverage of services to prevent, identify and address IPV.

- **Strategy.** DHCS should include addressing IPV in new Medi-Cal benefits and policy guides to MCPs about new benefits.

- **Strategy.** MCPs should acknowledge their responsibility to address IPV by including language in managed care contracts. Health plans are often unaware of children and youth who have experienced or been exposed to IPV because of insufficient pathways to identify those experiencing IPV, and insufficient services available to assist them. Exhibit 2 provides examples of managed care contract language from Massachusetts and North Carolina that require screening for IPV and delivery of needed services. Training providers on IPV and funding IPV advocates to provide services should follow the inclusion of MCP contract language.



“Calling out IPV specifically would...enhance and prioritize the need for practices and programs that tailor services for IPV prevention and intervention.”

—Clinic Behavioral Health Director

Exhibit 2. Language to address IPV in select MCP contracts

Screening

Massachusetts requires initial and ongoing comprehensive assessments for each enrollee and requires use of an assessment tool that includes risk factors for experiences of violence.

“As appropriate to the Enrollee’s needs and preferences, the Contractor-developed assessment tool will include the following domains and special considerations, which may be updated by Executive Office of Health and Human Services (EOHHS) during the Contract period:

- Risk factors for abuse and neglect in the Enrollee’s personal life or finances and for experiences of violence.”³⁹

Services

As part of the [Healthy Opportunities Pilots](#), North Carolina details the following four services for IPV survivors:

1. IPV case management
2. Transportation per member per month (PMPM) add-on for case management services
3. Holistic high intensity enhanced case management
4. Linkages to health-related legal supports⁴⁰

IPV case management:

“This service covers a set of activities that aim to support an individual in addressing sequelae of an abusive relationship. These activities may include:

- Ongoing safety planning/management
- Linkages to community-based social service and mental health agencies with IPV experience, including trauma-informed mental health services for family members affected by domestic violence, including witnessing domestic violence
- Referral to and provision of domestic violence shelter or emergency shelter, if safe and appropriate permanent housing is not immediately available, or, in lieu of shelter, activities to ensure safety in own home

Services

- Informal or peer counseling and advocacy related to Enrollees' needs and concerns. These may include accompanying the recipient to appointments, providing support during periods of anxiety or emotional distress, or encouraging constructive parenting activities and self-care."

Transportation PMPM Add-On for Case Management Services:

"Reimbursement for coordination and provision of transportation for Pilot Enrollees provided by an organization delivering one or more of the following case management services:

- Housing navigation, support and sustaining services
- IPV case management
- Holistic high intensity enhanced case management
 - o This service is for transportation needed to meet the goals of each of the case management services listed above."

Holistic High Intensity Enhanced Case Management:

"Provision of one-to-one case management and/or educational services to address co-occurring needs related to housing insecurity and interpersonal violence/toxic stress, and as needed transportation and food insecurities."

Linkages to Health-Related Legal Supports:

"This service will assist Enrollees with a specific matter with legal implications that influences their ability to secure and/or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress. This service may cover, for example:

- Assessing an Enrollee to identify legal issues that, if addressed, could help to secure or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress, including by reviewing information such as specific facts, documents (e.g., leases, notices, and letters), laws, and programmatic rules relevant to an Enrollee's current or potential legal problem;
- Helping Enrollees understand their legal rights related to maintaining healthy and safe housing and mitigating or eliminating exposure to interpersonal violence or toxic stress (e.g., explaining rights related to landlord/tenant disputes, explaining the purpose of an order of protection and the process for obtaining one);
- Identifying potential legal options, resources, tools and strategies that may help an Enrollee to secure or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress (e.g., providing self-advocacy instructions, removing a former partner's debts from credit rating);
- Providing advice to Enrollees about relevant laws and course(s) of action and, as appropriate, helping an Enrollee prepare "pro se" (without counsel) documents."

Recommendation 6. Encourage and incentivize IPV service providers to partner with BH providers to develop prevention and intervention programs for IPV using grant funding available in BH initiatives (for example, CYBHI's Scaling Evidence-Based and Community-Defined Evidence Practices, CYBHI's School-Linked Partnership and Capacity Grants, and MHSOAC's Innovation Incubator). [DHCS, MHSOAC, and other grant-administering agencies]

As part of grant programs, DHCS, MHSOAC, and other grant-administering agencies should offer funding and education to support IPV service providers in designing and implementing IPV prevention and intervention strategies.

Rationale. The U.S. National Plan to End Gender-Based Violence highlights the importance of investing in "upstream" education efforts which aim to promote healthy relationship dynamics, programming on consent, and other social-emotional learning programs.⁴¹ IPV service providers are well-positioned to offer these programs, which have been shown to reduce violence victimization and perpetration.^{42,43} Although recent grant funding available in California, such as through some CYBHI

workstreams, may have supported partnerships with IPV service providers and other CBOs to develop IPV prevention education programs, most IPV service providers we interviewed either did not know about the opportunities in Medi-Cal, or they did not know how to access them.

- **Strategy. DHCS, MHSOAC, and other grant-administering agencies should include IPV in the design of start-up grants, such as School-Linked Partnership and Capacity Grants, and encourage schools to partner with IPV service providers to create school-based education programs.** Exhibit 3 presents examples of existing school-based prevention programs.
- **Strategy. DHCS, MHSOAC, and other grant-administering agencies should engage and fund IPV advocacy organizations to publicize funding opportunities for IPV service providers and other CBOs to partner with BH providers or schools.** In addition, grant-administering agencies could work in partnership with IPV advocacy organizations to foster connections between IPV service providers and BH providers or schools seeking to implement IPV prevention and response programs.

One BH provider we interviewed acknowledged the importance of addressing IPV but expressed the need to engage external experts to provide best practices for preventing and identifying IPV, and connecting survivors with the appropriate CBOs in their communities. A child and youth advocacy organization described reaching out to its membership about the opportunity to pursue grant funding for early childhood development practices and programs under CYBHI's Scaling Evidence-Based and Community-Defined Evidence Practices. Similarly, IPV advocacy organizations may be able to publicize available state-funded grant opportunities to IPV service organizations to develop and expand IPV prevention and services within the BH system.

Exhibit 3. School-based IPV youth education programs provided in partnership with IPV service organization

As DHCS, MHSOAC, and other grant-administering agencies design grants for strengthening the BH system for children and youth, opportunities exist to integrate educational programs into accessible locations in the community, such as schools. The Healthy Relationships Campaign and Jeneration J are both examples of IPV education programs provided by partnership between CBOs and California school districts. The School Health Center Healthy Adolescent Relationship Program offers an example of providing IPV education within a school health center.

Healthy Relationships Campaign

Healthy Relationships Campaign began in 2019 with a grant from the Santa Clara County Office of Gender-Based Violence Prevention. The campaign, a partnership between Gilroy Unified School District and Community Solutions, includes:⁴⁴

- School-based prevention curriculum
- Trainings for school staff
- Workshops for parents of students
- Community awareness building activities during Teen Dating Violence Awareness Month⁴⁵

The healthy relationships campaign uses the In Touch with Teens Curriculum,⁴⁶ a curriculum on healthy relationships developed by community-based nonprofit Peace Over Violence. According to Peace Over Violence, the curriculum is one of five model youth-violence prevention programs recognized by the U.S. Department of Health and Human Services and the only model of its kind endorsed by California.⁴⁷

Community Solutions evaluated the Healthy Relationships Campaign and found that students' knowledge of the dynamics of healthy, nonviolent relationships, knowledge of and comfort with accessing community

Healthy Relationships Campaign

resources, and confidence in expressing their needs with dating partners increased after they received the school-based prevention curriculum.

Jeneration J

Jenesse Center's youth prevention program, Jeneration J, trains youth to share peer-to-peer knowledge and skills regarding healthy relationships, power dynamics, and identifying and preventing IPV. The program includes education components tailored to different age groups:⁴⁸

- Youth conversations, a student-directed discussion giving students a safe space to ask questions and share ideas about IPV
- Programs for college students to raise awareness about IPV and dating violence and educate about available resources
- Raise Your Voice for Peace, a singing competition for 13- to 18-year-olds performing original cover songs with a positive, uplifting message

The Jeneration J program was developed based on Break the Cycle's curriculum and adapted to best fit the needs of community members.⁴⁹

The School Health Center Healthy Adolescent Relationship Program (SHARP)

Clinic-based assessment, education, and prevention services can be an important intervention point for adolescents who may be experiencing IPV. Because school health centers (SHCs) are essential for delivering health services to adolescents,⁵⁰ they offer a unique opportunity to embed universal education (UE) and targeted intervention for adolescents experiencing IPV.⁵¹

The SHARP is an evidence-based intervention delivered by providers within an SHC during routine visits. It is offered universally, regardless of clinic visit type; inclusive of gender identity and sexual orientation; and addresses a range of abusive behaviors, including cyber dating abuse. The SHARP includes [clinical guidelines](#), training slides, and a small brochure that discusses healthy relationships, how to help a friend, and other resources to help with adolescent relationship abuse. An evaluation of the SHARP showed that overall, students who received services from SHC providers who implemented the SHARP reported a greater increase in recognition of sexual coercion than students who received services from providers who did not implement the intervention.⁵² In addition, among students who reported recently experiencing relationship abuse at baseline, those who saw providers implementing the SHARP reported an increase in their ability to recognize relationship abuse and knowledge of available resources compared to those who saw providers who did not implement SHARP.

- **Strategy. DHCS, MHSOAC, and other grant-administering agencies should facilitate conversations between CBOs running evidence-based or evidence-informed IPV prevention and intervention programs, IPV advocacy organizations, and Medi-Cal experts to help connect programs to sustainable funding.**

Many interviewees noted that the kinds of prevention and intervention programs that help address IPV for children and youth need the support of sustained funding, not just one-time funding. Programs that have shown promise, such as the Healthy Relationships Campaign (Exhibit 3) and ARISE (Exhibit 4), have ended due to funding cuts.



"It's hard to strengthen infrastructure with one-time funding... yes, there's lots of money [in grant opportunities], but we need a sustainability component as well."

—County Behavioral Health Director

New BH benefits, such as those in the Multi-Payer School-Linked Fee Schedule, may offer opportunities to sustain IPV prevention programs through reimbursement by Medi-Cal and other

health plans. However, potential program partners, such as schools and IPV service providers, would need to collaborate with Medi-Cal experts to understand how to take advantage of such opportunities.

Recommendation 7. Educate communities on the dynamics of IPV and services and supports that are available to them. [CalHHS, MCPs, and grant-administering agencies]

Rationale. Because individuals experiencing IPV may not have the capacity to actively seek out BH resources, they would benefit from information about the covered resources available to them.

Community education on IPV and its impact on health and BH are needed to reduce stigma with seeking assistance. For example, peer-to-peer education programs about IPV resources would be valuable in school settings. Education and engagement on IPV should be equitable and offered in culturally and linguistically accessible ways.



“Given historical distrust in social services, extending early intervention through these trusted community messengers [CHWs/*promotores*] is key.”

—IPV Advocate

- **Strategy.** CalHHS, MCPs, and grant-administering agencies should include trusted community workers like CHWs/ *promotores*, peers, wellness coaches, and doulas to educate and engage the community about new BH resources and services. To enhance cultural and linguistic accessibility of education and engagement, people who are undocumented and people with limited English proficiency should be included in these efforts. For example, Futures Without Violence partners with Alianza Nacional de Campesinas and Lideres Campesinas, UCSF Center to Advance Trauma-Informed Health Care, and other organizations on a pilot project to gather feedback from farmworker leaders on ways to expand screening for ACEs (see Appendix C for key terms) and response in the California farmworker community. The pilot will develop strategies, curricula, and tools for clinics statewide.⁵³

Recommendation 8. Publicize new benefits and services like the dyadic services benefit, the expanded family benefit, and school-linked BH services, so that IPV service providers and other CBOs are aware of them. [DHCS]

Rationale. Many IPV service providers and other CBOs we spoke with did not know that new opportunities to cover BH services, like dyadic services for children, are available or being developed for Medi-Cal beneficiaries.

- **Strategy.** DHCS and MCPs should partner with intermediaries such as IPV advocacy organizations to communicate opportunities to IPV service providers about new benefits, including how to deliver and bill for services. Many IPV service providers and CBOs may not know about new or expanded Medi-Cal benefits. Further, IPV service providers and CBOs may not understand their role in providing Medi-Cal benefits, or the settings in which they can provide services (for example, telehealth or school). In partnership with community IPV advocacy organizations, DHCS and MCPs should hold information sessions for IPV service providers to learn about:

- / DHCS’s overall goals and expectations for the new benefits
- / How new benefits relate to existing IPV and BH services
- / How to enroll people for benefits
- / How to bill for services

C. Design BH programs and benefits with IPV in mind

IPV is a serious and pervasive issue with root causes and effects that require additional services beyond immediate crisis services or intervention. Appropriately addressing IPV requires a nuanced approach to wraparound SDOH service provision, a broadened perspective on what constitutes BH treatment for children and youth, and inclusion of community input on the design of prevention and intervention efforts for IPV. This section describes recommendations for DHCS, MCPs, MHSOAC, and other grant-administering agencies about designing BH programs and benefits to address IPV. It also provides the evidence supporting these recommendations and actionable strategies to implement them (see Table 4).

Table 4. High-level recommendations and actionable strategies to design BH programs and benefits with IPV in mind for children, youth, and their families in California’s BH initiatives

Recommendations	Actionable strategies
<p>9. Require and fund more culturally and linguistically accessible case management and care coordination to holistically address IPV-related needs of children and families by promoting prevention, identifying risks of IPV, connecting patients to needed services, and following up with patients [DHCS and MCPs].</p>	<ul style="list-style-type: none"> • DHCS could require and MCPs could fund whole-person models of care that include case management and care coordination, such as embedded IPV advocates in clinics. This model of care has been demonstrated in a pediatric clinic. • MCPs could incorporate the expanded workforce of Medi-Cal workers, such as CHWs, peer support specialists, or doulas who are trained in IPV, in whole-person models of care because they are trusted members of the community. • DHCS should include IPV survivors and those at risk as a population of focus for ECM, a Medi-Cal benefit that provides coordination and care management that is person-centered and community-based. At a minimum, DHCS could release an all-plan guidance document to identify the various ways IPV survivors qualify for ECM (for example, risk for hospitalization, risk for housing instability).
<p>10. Encourage efforts that aim to expand BH services to incorporate IPV education, assessment, and response [DHCS and other grant-administering agencies].</p>	<ul style="list-style-type: none"> • DHCS and other grant-administering agencies could provide funding to grantees to incorporate IPV in their program design and help them develop and disseminate best practices for incorporating IPV in future programs.

Recommendations	Actionable strategies
<p>11. Include community advisory groups to inform, guide, and support the inclusion of IPV prevention and early intervention services in programs to expand and strengthen the BH system [DHCS, MHSOAC, and MCPs].</p>	<ul style="list-style-type: none"> DHCS, MHSOAC, other grant-administering agencies, and MCPs should ask communities about their specific needs and recommendations related to IPV prevention and intervention. They should seek out and compensate trusted community members who can serve as advocates for their communities. Grant administering agencies and MCPs can also use requests for information (RFIs) before developing a program.

BH = behavioral health; CHW = community health worker; DHCS = Department of Health Care Services; ECM = enhanced care management; IPV = intimate partner violence; MCP = managed care plan; MHSOAC = Mental Health Services Oversight and Accountability Commission.

Recommendation 9. Require and fund more culturally and linguistically accessible case management and care coordination to holistically address IPV-related needs of children and families by promoting prevention, identifying risks of IPV, connecting patients to needed services, and following up with patients. [DHCS and MCPs]

Rationale. Non-specialty MH services, like those offered in family therapy, are not meant to provide intensive treatment. However, IPV is an issue that may require a care continuum from mild-to-moderate mental health services to intensive supports with wraparound SDOH services throughout.^{54,55} Care coordination and case management, for example through Medi-Cal’s ECM, which can help survivors connect to all these services as their needs change, provide support that primary care providers like pediatricians do not have the capacity to give parents and survivors.

- **Strategy.** DHCS could require and MCPs could fund whole-person models of care that include case management and care coordination, such as embedded IPV advocates in clinics. Exhibit 4 offers an example of an IPV program embedded in a clinical setting. MCPs could incorporate members of the expanded health care workforce, such as CHWs/*promotores*, peer support specialists, or doulas who are trained in IPV, in whole-person models of care for IPV because they are often trusted members of the community.

Sustained funding for case management and care coordination is a challenge in clinical settings. One interviewee said that BH and pediatric providers do not have access to care coordination services needed to effectively connect to BH or SDOH supports. They noted that, “For the settings where we can identify [IPV] issues, we don’t have the workforce [to assist them].” The embedded IPV advocate program that Exhibit 4 describes closed because funding could not be maintained. However, a BH Director indicated that the new dyadic services benefit and ECM could offer an opportunity to fund such a program in partnership with a community-based IPV service provider.



“There is a sustainability opportunity to fund and support these services [IPV advocate]. It just needs to be demonstrated.”

—BH Director

Exhibit 4. Case study: Aspire to Realize Improved Safety and Equity (ARISE) program

The University of California, San Francisco (UCSF), in partnership with La Casa de las Madres, BayLegal, The Trauma Recovery Center, and Futures Without Violence, implemented the ARISE program.⁵⁶

ARISE co-located IPV advocates from La Casa de las Madres into five hospital-based clinics in the San Francisco Health Network (SFHN), including a pediatric clinic. The role of the advocate was to work directly with patients who disclosed IPV and connect them to an IPV service provider and other community-based resources. ARISE trained more than 1,700 health care staff and providers on trauma-informed care principles and a UE method of addressing IPV. The [UE method](#) ensures that regardless of IPV disclosure, providers share information on healthy relationships, the effects of relationships on health, the connection between IPV and patients' health concerns, and information on accessing helpful clinic and community resources.⁵⁷

ARISE and SFHN developed the Behavioral Health Vital Signs (BHVS) screening tool to identify patients who benefit from connection with ARISE IPV advocate and community-based services.⁵⁸ The six-question screening tool served as a key piece of an overall systems approach to a trauma-informed IPV program, which included:

- Provider and staff training
- Screening and response protocols
- Electronic health record (EHR) templates and data
- Continuous quality improvement
- Patient education
- Expedited referrals

ARISE reported increases in screening for IPV, patient disclosure of IPV, and connection to community-based IPV service organizations after referral.

- **Strategy. DHCS should include IPV as a population of focus for ECM, a Medi-Cal benefit that provides coordination and care management that is person-centered and community-based.** DHCS could release an all-plan guidance document to identify the various ways IPV survivors qualify for ECM (for example, risk for hospitalization, risk for housing instability). The populations of focus that are covered under the ECM include adults and children with serious mental health diagnoses, substance use, or significant clinical risk for experiencing psychosis. Further, individuals and families who are unhoused are eligible for ECM, and DHCS specifically uses housing instability resulting from IPV as an example of eligibility.⁵⁹ Including the experience of IPV explicitly as its own population of focus, or identifying how survivors could qualify for ECM, would create opportunities for IPV survivors to connect to essential services such as housing support, financial support, and child care.

Recommendation 10. Encourage efforts that aim to expand BH services to incorporate IPV education, assessment, and response. [DHCS, MHSOAC, and other grant administering agencies]

Rationale. Incorporating IPV education, assessment, and response would strengthen many existing efforts to expand BH services for children and youth. Because the experience of IPV can be associated with psychological symptoms such as anxiety, depression, or other mental health related symptoms, addressing IPV can be one effective intervention for these concerns.⁶⁰ IPV education using the [CUES method](#) helps survivors who do not disclose IPV, or who may not realize they have

experienced IPV.[∨] Appropriate IPV assessment and response ensures that survivors who disclose experiences of IPV are connected to support services to address urgent needs that would then allow them to address their BH needs.

Examples of existing California efforts to expand BH services that could benefit from incorporating IPV education, assessment, and response include the MHSOAC's allcove youth wellness centers, CYBHI's School-Linked Partnership and Capacity Grants, and CYBHI's Multi-Payer School-Linked Fee Schedule for BH services. The allcove youth wellness center is an evidence-based, peer-driven BH support model for youth.⁶¹ MHSOAC is funding the replication of this model in several additional California counties, which offers a unique opportunity to incorporate training on IPV, including resources, UE, and connection to community IPV service providers into the development of these centers. Several CBOs, BH providers, and advocacy organizations we interviewed recognized the opportunity to identify and address IPV in schools, which are often first responders in BH situations for youth. CYBHI's School-Linked Partnership and Capacity Grants and Multi-Payer School-Linked Fee Schedule for BH services offer opportunities to promote prevention and intervention by increasing access to IPV prevention education, screening and resources through BH services that youth are already receiving at school (Exhibit 3).^{62,63}

- **Strategy.** DHCS and other grant-administering agencies could provide new funding to organizations, such as those that have already been awarded grants by CYBHI or MHSOAC, for example, to incorporate IPV in their programming and then contract with IPV experts to help grantees develop and disseminate best practices for incorporating IPV in future programs. For example, DHCS should make the case for addressing IPV in school-linked programs by sharing evidence on the impact that teen dating violence has on BH, school attendance, and educational outcomes.⁶⁴ DHCS could offer ongoing TA and funding to school-linked BH programs and other BH programs to introduce IPV prevention efforts such as UE, assessment, and response. DHCS could also encourage and fund connections between organizations that have been awarded grants and community IPV service organizations. To inform future program design, DHCS and other grant-administering agencies should include funding to specifically evaluate IPV outcomes of grantee programs and develop best practices for addressing IPV in BH programs.

Recommendation 11. Include community advisory groups to inform, guide, and support the inclusion of IPV prevention and early intervention services in new benefits and grant-funded programs to expand and strengthen the BH system. [DHCS, MHSOAC, other grant-administering agencies, and MCPs]

Rationale. All communities encompass families and individuals with unique backgrounds, cultures, customs, and values. Including the range of ideas and knowledge from these communities when strategizing areas for improvement ensures that people have a voice in the policies and practices used to address the issues that affect them. For BH and IPV, which often have social stigma attached to them, community input is essential.

[∨] CUES is an evidenced-based method of providing UE and support for IPV. Irrespective of patient disclosure of IPV, providers share information on how relationships affect health, how IPV could be related to patients' health concerns, and how patients can access helpful clinic and community resources.

- **Strategy.** DHCS, MHSOAC, other grant-administering agencies, and MCPs should ask communities about their specific needs and recommendations related to IPV prevention and intervention. They should seek out and compensate trusted community members who can serve as advocates for their communities. Trusted members do not have to be those with assigned leadership roles. “[Look for] informal leaders who can help with messaging...youth, adults, or elders who are already visible in the community...who have maintained and built trust,” advised one director of an IPV advocacy organization. Grant-administering agencies and MCPs can also release RFIs to community IPV service organizations and other CBOs before developing a program, which can be helpful in communities where MCPs are not already connected with local IPV service providers.

D. Recommendations for California's overarching BH system

Even as California makes progress toward addressing IPV in specific BH initiatives, changes must also be made to the overarching BH system to support children, youth, and families at risk of or experiencing IPV. Recommendations include:

Recommendation 12. Integrate non-specialty mental health (NSMHS) and specialty mental health systems (SMHS).

BH providers we interviewed said that survivors may experience difficulty navigating services within the state's two mental health systems if survivors require both SMHS and NSMHS, or if survivors need to transition between SMHS and NSMHS (see Appendix C for key terms). Improving integration of NSMHS and SMHS through care coordination, case management, workflow design, and communication pathways would support children, youth, and their families as their BH needs change across the course of their lives. IPV advocacy organizations said that IPV advocates who are appropriately trained in BH and adequately paid could assist survivors navigating between the two mental health systems. In California, SMHS are delivered by County Mental Health Plans (MHPs) and include services for intensive mental health needs. NSMHS, however, are delivered by Medi-Cal MCPs and include services for mild-to-moderate mental health needs.⁶⁵

Recommendation 13. Strengthen the continuum of care for mild-to-moderate and more intensive mental health needs.

Survivor-centered services must address the full continuum of BH and IPV needs, including prevention, intervention, and ongoing support to adequately address IPV. Currently, BH experts in California report that children and youth covered by Medi-Cal experience gaps in access to intensive mental health services (such as partial hospitalization treatment and crisis residential centers) and less intensive mental health services (such as prevention and early childhood intervention).⁶⁶

Recommendation 14. Integrate BH and SDOH supports.

Integration of BH and SDOH supports can address issues like housing and financial security, which often impede a survivor's ability to leave a violent relationship.^{67,68,69} The integration of BH and services to address SDOH requires a multifaceted systems approach, including establishing interoperability standards to increase SDOH data collection and referrals, expanding community-based services offered by CHWs, and building partnerships among state and local governments and CBOs.⁷⁰ As noted above, IPV advocates can help coordinate between these systems of care.

III. Conclusion and Next Steps

Experience of—or exposure to—IPV often begins in childhood and can lead to mental and behavioral health challenges that, if unaddressed, can extend into adulthood and contribute to multigenerational cycles of violence. Within California's current and future BH initiatives, there are opportunities to prevent, identify, and address IPV for children, youth, and families. By training BH providers on the power dynamics in violent relationships, health impacts, and protections for survivor safety and security, and by expanding TA for benefits like dyadic services that support IPV prevention, CalHHS and MCPs can give providers, schools, and other grant-funded organizations the tools needed to assist IPV survivors. CalHHS, other grant-administering agencies, and MCPs can use several strategies to boost provider and community engagement with IPV services: include expectations for addressing IPV in new BH benefits and MCP contracts, encourage IPV service providers and other CBOs to pursue available grant funding for new BH programs, and educate providers and the community about new IPV services and supports. Truly incorporating IPV into BH programs and benefits requires DHCS, other grant-administering agencies, and MCPs to integrate evidenced-informed strategies for identifying and addressing IPV into the design of programs and benefits and into service criteria for case management and care coordination. Finally, to ensure survivor-centered care in BH initiatives, CalHHS, other grant-administering agencies, and MCPs should engage IPV service organizations, advocates, and survivors throughout the process of designing, developing, and implementing educational and training activities, BH programs, and benefits.

California's considerable efforts to expand and bolster the BH system for its residents, including children, youth and families, presents a tremendous opportunity to integrate an IPV lens in BH initiatives to break the cycle of violence.

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Appendix A. Approach

Mathematica aimed to answer key research questions about addressing IPV for children, youth, and families in California's BH initiatives. To do so, we conducted an environmental scan from June to August 2023, convened an advisory council of IPV service providers and policy advocates in California in July 2023, and conducted interviews with key informants from June to September 2023. Key informants included children and youth advocacy organizations, a Medi-Cal MCP, IPV advocacy organizations, IPV service providers, and BH providers.

Discussions with the advisory council members and key informants focused on BH initiative activities and BH programs that have potential to address IPV and build partnerships between BH providers, IPV service providers, and other CBOs.

Key research questions

- How do California BH initiatives, such as the CYBHI workstreams and MHSOAC programs and projects, currently integrate evidence-based, evidenced-informed, or emerging practices for IPV prevention and early intervention for children, youth, and families?
- Where are the opportunities for California BH initiatives to elevate IPV awareness, prevention, assessment, and response?
- How might BH initiatives, such as CYBHI workstreams and MHSOAC programs and projects, pilot interventions that prevent or address IPV?
- What may challenge efforts to elevate IPV in California's BH initiatives? How can CalHHS and other California-based policymakers help address these challenges and support partners in these efforts?
- How is California implementing the dyadic services benefit and the family therapy benefit?

Appendix B. Summary of California’s BH Initiatives

Table B.1 provides summaries of California’s recent initiatives to expand and strengthen BH services. It also includes the type of initiative and references for more information.

Table B.1. Select California BH initiatives

Initiative	Type	Summary
Children and Youth Behavioral Health Initiative (CYBHI)	Medi-Cal and multi-payer benefit, infrastructure and capacity, public awareness, health workforce	<p>CYBHI is a \$4.6 billion, five-year initiative to support access of mental health and substance use services for children and youth “where, when, and in the way they need it most.”⁷¹ The initiative includes 20 workstreams across four areas: coverage, BH infrastructure, public awareness, and workforce training and capacity.⁷²</p> <p>Initiatives with opportunities to address IPV include the following workstreams:</p> <ul style="list-style-type: none"> – Enhanced Medi-Cal Benefits – Dyadic Service – Statewide Multi-Payer School-Linked Fee Schedule for BH services (formerly known as Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services) – Scaling Evidence-Based and Community-Defined Evidence Practices – School-Linked Partnership and Capacity Grants – Youth Peer-to-Peer Support Program – Adverse Childhood Experiences (ACEs) and Toxic Stress Awareness Campaign
CYBHI: Enhanced Medi-Cal Benefits: Dyadic Services	Medi-Cal benefit	<p>On January 1, 2023, DHCS implemented the dyadic care services (that is, preventative BH services for children, youth, and their caregivers) as a covered benefit under Medi-Cal. Covered services include behavioral well-child visits, navigation and follow up for referrals, psychoeducation, family training and counseling, and specified mental and BH screenings for caregivers.⁷³ The design of the dyadic services benefit stems from evidenced-based models of pediatric primary care (for example, HealthySteps and Dulce)^{74,75} that consider the family’s cross-sector needs, from behavioral health to social support services, during well-child visits.</p> <p>The timeline for this workstream is 2023–2026.</p>

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Initiative	Type	Summary
<p>CYBHI: Multi-Payer School-Linked Fee Schedule (formerly known as Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services)</p>	<p>Multi-payer benefit</p>	<p>The DHCS and Department of Managed Health Care (DMHC) will develop and maintain a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services for students ages 25 or younger that are provided at or near a school site. DHCS and DMHC will publish the fee schedule in December 2023. DHCS will also develop and maintain a school-linked statewide provider network of BH counselors.⁷⁶</p> <p>Beginning January 1, 2024, the state statute (W&I Code 5961.4) requires Medi-Cal MCPs and Medi-Cal BH delivery system to reimburse providers of medically necessary outpatient mental health or substance use treatments delivered at or near school sites. Providers will be reimbursed, at minimum, at the fee schedule rate regardless of their network provider status. The categories of services in the fee schedule include: psychoeducation, screenings and assessments, treatment, and care coordination.</p> <p>The goals of this workstream include:</p> <ul style="list-style-type: none"> - Increase access to school-linked BH services for children and youth - Create a more approachable billing model for schools and local educational agencies (LEAs) - Ease burdens for LEAs related to contracting, rate negotiation, and navigation across delivery systems - Reduce uncertainty around students’ coverage, thereby eliminating barriers to care. <p>The timeline for this workstream is 2021–2025.</p>
<p>CYBHI: Scaling Evidence-Based and Community-Defined Evidence Practices</p>	<p>Infrastructure</p>	<p>DHCS is distributing grants to organizations looking to scale evidence-based practices (EBP) and/or community-defined evidence practices (CDEP) that improve youth BH outcomes, racial equity, outcomes for the LGBTQIA+ community, or sustainability.^{77,78} Through these grant-funding opportunities, DHCS aims to improve youth BH prevention and early interventions. The program types fall into three categories: (1) expanding an organization’s operations and capacity to provide services, (2) enabling the replication and adaptations of well-established practices, and (3) exploring potential policy innovations that could lead to sustainable funding strategies. DHCS has awarded, or plans to award, funding in the following focus areas:</p> <ul style="list-style-type: none"> - Round 1: Parent/caregiver support programs and practices (Closed) - Round 2: Trauma-informed programs and practices (Closed) - Round 3: Early childhood wraparound services (Closed) - Round 4: Youth-driven programs (Closed) - Round 5: Early intervention programs and practices (Closed) - Round 6: Community-defined programs and practices (Timing has not been announced yet) <p>The timeline for this work is 2022–2024.</p>

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Initiative	Type	Summary
CYBHI: School-Linked Partnership and Capacity Grants	Infrastructure	<p>DHCS will award \$550 million in one-time grants to strengthen school-linked BH services and provide California public K-12 schools (about \$400 million) and institutions of higher education (about \$150 million) with resources to support institutional readiness for the statewide multi-payer fee schedule. The grants will provide resources to schools to expand provider capacity, develop critical partnerships, and build necessary infrastructure. The grants will be managed by a third-party administrator.⁷⁹</p> <p>The goals of the workstream include:</p> <ul style="list-style-type: none"> - Increase the number of students who receive preventive and early-intervention BH services. - Provide direct grants to support new services for individuals ages 25 and younger through schools, providers in school, school-affiliated CBOs, or school-based health centers. - Support statewide implementation of school-linked fee schedule and BH network of providers. <p>The timeline for this work is late 2023-2025.</p>
CYBHI: Youth Peer-to-Peer Support Program	Infrastructure	<p>DHCS and The Children’s Partnership will award grants to up to eight high schools (grades 9–12) in urban, suburban, and rural areas of the state to implement high school peer-to-peer pilot programs. The goal of this initiative is to define best practices and develop statewide standards for peer support programs.⁸⁰</p> <p>The timeline for this workstream is 2023–2027.</p>
CYBHI: ACEs and Toxic Stress Awareness Campaign	Public awareness	<p>California Office of the Surgeon General (CA-OSG) is launching a statewide campaign to raise awareness of ACEs and toxic stress, emphasizing the impact of trauma on childhood health and development, as well as resources available for screening, treatment, and prevention. The campaign will provide practical strategies that parents, caregivers and young people can employ to ease stress.⁸¹ As part of the state’s ongoing commitment to equity and accessibility, the campaign will focus on reaching:</p> <ul style="list-style-type: none"> - Economically disadvantaged communities - LGBTQ+ communities - Communities of color - Rural communities - Juvenile justice-involved youth - Child welfare-involved youth - Transition-age youth ages 18–24 - Immigrants and refugees <p>The timeline for this workstream launch is Spring 2024.</p>

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Initiative	Type	Summary
Enhanced Care Management	Medi-Cal benefit	ECM is a whole-person, interdisciplinary approach to address nonclinical needs of Medi-Cal members with complex medical and social needs. ⁸² The ECM Medi-Cal benefit aims to offer coordination services and provide comprehensive care management that is person-centered and community-based. Requirements proposed under CalAIM and enacted under Assembly Bill 1333 require MCPs to provide ECM for specific high-need populations, including people experiencing housing instability, people with serious mental illness, serious emotional disturbance, or substance use disorders.
Family Therapy Benefit	Medi-Cal benefit	Family therapy is a NSMHS benefit that Medi-Cal has covered since 2020. On March 2023, DHCS issued a guidance document to managed care plans indicating that both children and adult Medi-Cal members can receive family therapy services as medically necessary to improve parent-child or caregiver-child relationship. ⁸³ Parents and caregivers can qualify for therapy without their child present, as the purpose of therapy is to address family dynamics as they relate to the child’s mental health status and behavior. DHCS requires MCPs to provide family therapy to children and youth (younger than 21) who are at risk for BH concerns but may not have a mental health diagnosis. For example, children and youth with parents and caregivers with listed risk factors, including a history of IPV or interpersonal violence, could receive this benefit.
Mental Health Services Oversight and Accountability Commission (MHSOAC)	Infrastructure and capacity	<p>MHSOAC has authority and responsibility to innovate change related to mental health care, as directed by the Mental Health Services Act (MHSA). The MHSOAC oversees the development of sustainable mental health care systems in California counties and approves county funding for prevention and early intervention programs.^{84,85}</p> <p>MHSOAC advises the legislature and administration, provides technical assistance (TA), and evaluates counties’ spending and performance. It has programmatic authority over activities for prevention and early intervention and the Innovation program as it funds and administers grants in counties across the state.</p> <p>Initiatives with opportunities to address IPV include the following activities:</p> <ul style="list-style-type: none"> - allcove™ Youth Drop-In Centers - Innovation Incubator

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Initiative	Type	Summary
MHSOAC: allcove Youth Drop-In Centers	Infrastructure	<p>MHSOAC has funded five grantees (allcove centers)⁸⁶ to increase early access to mental health care for youth ages 12–25 and their families, with some of the main goals to reduce suicidality, housing instability, unemployment, and school failure. Stanford Center for Youth Mental Health and Wellbeing provides TA to the grantees to help the allcove centers adapt an international, youth equity model which creates integrated health centers for youth to provides mental and physical health services, employment and school support, and substance use services.^{87,88} Allcove centers are led by a local youth advisory group to design the services and environment that meet the needs they see in their community.</p> <p>The five funded centers are:</p> <ul style="list-style-type: none"> – Beach Cities Health District, LA County – Peninsular Health Care–District, San Mateo County – Sacramento County Behavioral Health Services – Wellnest© (City of South LA) – University of California–Irvine & Wellness and Prevention Center <p>The timeline for this work is 2020–2024.</p>
MHSOAC: Innovation Incubator	Infrastructure and capacity	<p>For California counties that have identified an opportunity for improvement in BH, the Incubator links them with BH subject matter experts (SMEs) and experienced practitioners to adapt, test, and assess novel strategies and services to promote better mental health outcomes for individuals and communities. In addition to developing specific advances in service delivery, the Incubator supports cross-county collaboration, and building capacities within counties for performance management and continuous improvement.⁸⁹ The Incubator was a unique model that allowed counties receiving MHSA funds to work on any of eight collaborative projects headed by SMEs (for example, crisis response system, psychiatric advance directives). All counties receiving MHSA funds must use 5 percent of funds to support innovation. The SMEs offered TA and facilitated learning to help counties develop a MHSA innovation plan that used strategies for their local needs and built capacity for system-level changes.⁹⁰</p> <p>The first set of eight incubator projects began in 2019 and concluded by end of 2022. As of June 15, 2023, MHSOAC approved three additional innovation incubator projects for three counties totaling \$231 million.⁹¹ These projects would address services for youth, workforce challenges, and housing services. In addition, MHSOAC also approved 28 innovation projects, totaling \$122 million, that focus on a statewide enhanced electronic health record system, integrated care, crisis response, peer-led services, and services for underserved populations.</p>

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Initiative	Type	Summary
Community Health Worker Benefit	Health care workforce expansion	In 2022, California became the only state to specifically extend Medicaid coverage to include CHW services related to IPV and violence prevention. California’s SPA that adds CHW services as a Medi-Cal benefit went into effect July 1, 2022. On June 27, 2022, California also approved a state budget that included a health care workforce initiative, which will invest \$281.4 million to develop and deploy 25,000 CHWs by 2025. ⁹²
Peer Support Benefit	Health care workforce	<p>The Medi-Cal Peer Support Service benefit, launched in July 2022, established peer support specialists as an approved Medi-Cal provider type. Peer specialists offer distinct services under the SMHS and DMC-ODS programs.⁹³ Peer support specialists can provide education, skills building, coaching, engagement, and nonclinical therapeutic activities to promote wellness, self-advocacy, and support (for example, resource navigation, collaboration with other providers of care),^{94,95} Peer support services are available to parents and legal guardians of beneficiaries ages 17 and younger when the service benefits the beneficiary.</p> <p>Peer support specialists are individuals who self-identify as having lived experience with mental health and/or substance use, as either a consumer of services, or a parent or family member of a consumer, and are certified under a California county Medi-Cal Peer Support Specialist certification program.</p>
Doula Services Benefit	Health workforce	Doula services became an approved Medi-Cal benefit in April 2023. Doulas can apply to be a Medi-Cal provider and are then able to bill directly to Medi-Cal for the services they provide. Doula coverage offers the opportunity for more physical and emotional support throughout the pregnancy, birthing, and postpartum periods and represents a more culturally responsive approach to care. ⁹⁶

ACEs = adverse childhood experiences; BH = behavioral health; CBO = community-based organization; CHW = community health worker; CYBHI = Children and Youth Behavioral Health Initiative; DHCS = Department of Health Care Services; DMC-ODS = Drug Medi-Cal Organized Delivery System; ECM = enhanced care management; IPV = intimate partner violence; MCP = managed care plan; MHSA = Mental Health Services Act; MHSOAC = Mental Health Services Oversight and Accountability Commission; NSMHS = non-specialty mental health services; SMHS = specialty mental health services; SPA = state plan amendment; TA = technical assistance.

Appendix C. Key Terms

Table C.1 describes many of the key terms and concepts discussed throughout this policy brief and includes references for more information.

Table C.1. Table of key terms and definitions

Term	Definition
Adverse childhood experiences (ACEs)	ACEs are potentially traumatic experiences that happen during childhood and adolescence (ages 0–17) that include, but are not limited to, experiencing physical, emotional, or sexual abuse, witnessing violence in the home, and parental separation. While the original ACEs study, published by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente (1998) defines interpersonal-level ACEs, recent literature also identifies adverse community environments that impact people’s lifelong health. ^{97,98,99,100}
Behavioral health (BH)	Behavioral health is an umbrella term that includes mental health, substance use, life stressors, crises, health behaviors, and emotions and behaviors that affect a person’s overall wellbeing. ^{101,102}
BH provider	An organization or provider (such as psychologists, psychiatrists, physicians, counselors, therapists, clinical social workers, and nonclinical BH care extenders, such as peer support specialists and CHWs) who treats issues related to a patient’s BH. ¹⁰³
Care coordination	Includes many of the tasks that would fall under case management, but often exists within a broader programmatic context and includes integration of services among care sectors and for a population of patients. ¹⁰⁴
Community health workers/ <i>promotores</i> (CHWs)	CHWs, known as <i>promotores</i> in Spanish-speaking communities, are frontline public health workers who are trusted members of and have a close understanding of the communities they serve. This trusting relationship enables CHWs to serve as a liaison between health, social services, and communities to facilitate access to services and improve the quality and cultural competence of service delivery. ¹⁰⁵
Case management	A process in which a provider helps develop a plan for the patient’s care that coordinates and integrates both health care and psychosocial needs to meet patient-centered goals. ¹⁰⁶
Dyadic services	Integrated physical and BH screening and services designed to address children’s developmental and behavioral health needs. Children and caregivers can receive services together or separately. ¹⁰⁷
Family therapy	A form of psychotherapy that focuses on the improvement of dynamics and interpersonal relationships within a family. ¹⁰⁸
Gender-based violence	Any harm, public or private, that is perpetrated against a person, or a group of people, based on their actual or perceived gender, sex, or gender identity/sexual orientation. ¹⁰⁹ IPV is a form of gender-based violence.
Grant-administering agencies	Organizations or entities that fund and administer grants, such as states, territories, tribes, foundations, and federal agencies.
Intimate partner violence (IPV)	The CDC defines IPV as physical, psychological, and sexual violence, and/or stalking perpetuated by a current or former intimate partner. ¹¹⁰ In this policy brief, domestic violence is included under our umbrella of IPV language.

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Term	Definition
IPV advocate	A person who works with IPV survivors to connect them to resources and protections and to represent their rights and interests. ¹¹¹
IPV service provider	An organization or provider whose primary purpose is to provide services to survivors of IPV.
Local educational agency (LEA)	School district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind. ¹¹²
Managed health care plan (MCP)	A health care plan contracted by state or commercial agencies to provide the delivery of health care benefits and services to its beneficiaries. ¹¹³
Mandated reporting/mandated reporter	<p>According to the State of California Child Welfare Services Manual of Policies and Procedures, a mandated reporter is defined as:</p> <p><i>“...a person who, pursuant to the Child Abuse and Neglect Reporting Act, is required to report knowledge or reasonable suspicion of child abuse which is obtained while acting in a professional capacity or within the scope of his/her employment. Such persons include child care custodians, health practitioners, employees of child protective agencies, child visitation monitors, and commercial film and photographic print processors, pursuant to Penal Code Sections 11165 through 11166.”¹¹⁴</i></p> <p>Mandated reporters are required to make their report by phone as soon as possible and follow up with a completed written report within 36 hours.¹¹⁵</p>
Mental health	Mental health includes emotional, psychological, and social well-being, as well as how an individual thinks, feels, and behaves. ¹¹⁶
Non-specialty mental health services (NSMHS)	<p>Services delivered by Medi-Cal MCPs. Covered services include:</p> <ul style="list-style-type: none"> – Individual and group mental health evaluation and treatment (psychotherapy) – Psychological testing – Outpatient services for monitoring drug therapy and for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning – Outpatient laboratory, drugs, supplies, and supplements – Psychiatric consultation¹¹⁷
Polyvictimization	Multiple and cumulative experiences of violence across a person’s lifetime. ¹¹⁸
Social determinants of health (SDOH)	Conditions in the environment that affect a broad range of health, functioning, and quality of life risks and outcomes such as safe housing, discrimination, education, access to nutritious food and more. ¹¹⁹

Term	Definition
Specialty mental health services (SMHS)	<p>Services delivered by county mental health plans (MHPs). Covered services include:</p> <ul style="list-style-type: none"> - Rehabilitative mental health services (which includes mental health treatment, medication support, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment, crisis residential treatment, and psychiatric health facility services) - Psychiatric inpatient hospital services - Targeted case management - Psychiatrist services - Psychologist services - Psychiatric nursing facility services - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) specialty mental health services (including intensive care coordination, intensive home-based services, therapeutic behavioral services, and therapeutic foster care)¹²⁰
Survivor-centered	<p>A survivor-centered approach creates a supportive environment, ensures safety and dignity to promote a survivor’s well-being and reinforces the survivor’s capacity to make decisions.¹²¹</p>
Trauma-informed care	<p>Trauma-informed approaches deliver care with an understanding of the vulnerabilities and experiences of trauma survivors, including the prevalence and physical, social, and emotional impact of trauma. Elements of trauma-informed care include awareness of the effects of trauma on survivors, physical and emotional safety for survivors, trustworthiness in processes and relationships, empowerment in decision-making processes, and inclusiveness for all, including individuals from historically marginalized groups and people with disabilities. Adapted from Office of Victims of Crime Training and Technical Assistance Center and National Network to End Domestic Violence.</p>

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