LIFT'S Model and Two-Generation Prevention of Intimate Partner Violence

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2022

LIFT

EXECUTIVE SUMMARY

LIFT's programming aims to reduce generational poverty by supporting parents' financial strength, wellbeing, and social connection. But poverty isn't the only outcome LIFT's work is improving.

LIFT's model of cash transfers, economic mobility coaching, and events that build social connection is a promising, novel, and evidence-informed approach for preventing intimate partner violence across two generations: for both LIFT members AND for their children. This two-generation IPV prevention strategy can reduce Adverse Childhood Experiences and improve social determinants of health for LIFT families.

LIFT's Theory of Change for two-generation intimate partner violence prevention

The Problem.

1. HIGH RISK FOR INTIMATE PARTNER VIOLENCE (IPV)

Low income, economic stress, social isolation, poor well-being (like mental health and self-efficacy), societal marginalization, and other factors increase people's risk of experiencing IPV.

2. CYCLE OF VIOLENCE FOR SURVIVORS

Experiencing IPV worsens many of the factors that increase risk of IPV. In addition to physical injury, survivors of IPV often experience increased economic stress, social isolation, and mental health challenges, and decreased general well-being. These are challenges on their own, and they also increase the risk that survivors will experience more violence. The economic challenges associated with IPV can be particularly detrimental to survivors and their families, as their economic status is deeply intertwined with a host of social determinants of health, which are the conditions where people live, learn, work, and play that affect a wide range of health outcomes.

3. CYCLE OF VIOLENCE FOR CHILDREN

IPV against parents also increases their children's risks of experiencing and perpetrating IPV later in life. Exposure to IPV against a parent is one of the most commonly measured Adverse Childhood Experiences (ACEs) and can harm children's attachment to parents, social skills, mental health, and well-being. And economic stress in the family directly increases kids' risk of experiencing IPV as teens and adults.

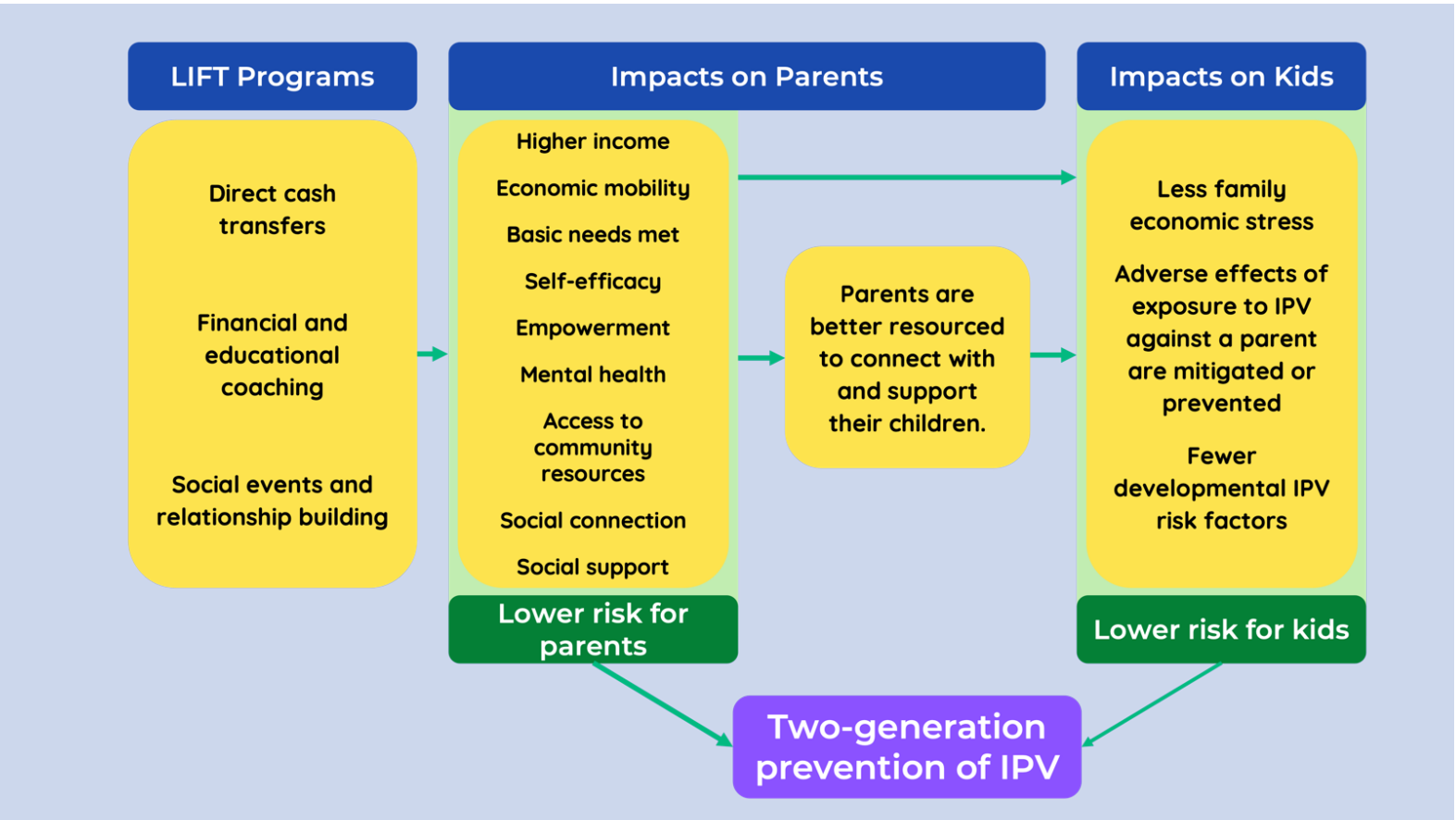
4. FEEDBACK LOOP

This creates a feedback loop. IPV exposure is both a risk factor for subsequent social and emotional challenges and can also be an outcome of these challenges.

The Solution.

LIFT's approach can help parents avoid IPV, whether that's preventing first-time experiences of violence or preventing further violence among parents who are survivors. AND LIFT's work with parents can help reduce their children's risk of ever experiencing IPV themselves later on in life. The LIFT model helps members' children both directly (e.g., by reducing family economic stress), and indirectly, by ensuring parents have the social, financial, mental, and emotional resources to mitigate the impacts of exposure to IPV on their children. Since research shows that ACEs are critical to lifetime health outcomes, LIFT's model can have lasting, far-reaching benefits for members' children. This stands to interrupt the feedback loop wherein IPV is a cause and a consequence of broad social and economic challenges.

The Theory of Change.



How do we know?

1 Literature Review

We reviewed the literature on IPV prevention to explore:

- All the influences that have been demonstrated to either increase or reduce the risk of IPV;
- The intergenerational impacts of being exposed to IPV as a child; and
- Potential two-generation prevention pathways and interventions.

The review identified many factors that are related to both LIFT's program model and IPV risk, including through intergenerational pathways. Improving these factors that influence IPV risk can help prevent IPV in the future. **The existing evidence base provides robust support for LIFT's Theory of Change for Two-Generation IPV Prevention.**

2 Well-being Survey

We analyzed LIFT's existing well-being survey. We matched questions from the survey with related risk and protective factors for IPV and found that LIFT's programming demonstrated significant reduction in LIFT members' risk for IPV across almost every risk and protective factor assessed. We also disaggregated results by race and by primary language spoken and found no statistically significant differences in results between groups. This means **LIFT's programming has already demonstrated success in making changes that support IPV prevention, without exacerbating existing inequities.**

LIFT's unique promise

- **IPV is an intergenerational issue, and prevention efforts should include intergenerational strategies.** Children who witness IPV against a parent or caregiver are more likely to both experience and perpetrate IPV in the future. Witnessing IPV is also classified as an Adverse Childhood Experience, which increases lifelong risk for depression, chronic diseases, stroke, risky health behaviors, and socioeconomic challenges.[1] But there are lots of ways parents and caregivers who are survivors can help reduce that risk for their children along the way.

- Improving parental or family economic stability to improve social determinants of health (SDOH) and prevent future IPV for both parents and their children is a **promising, innovative two-generation approach to IPV prevention.**

- **LIFT can enhance the evidence base for two-generation IPV prevention by expanding evaluation of their current programming.** The report did not identify any previous studies of prevention efforts that intervened on parental or family economic stability and assessed changes in risk or protective factors or violence outcomes among children. However, the theory behind this approach is supported by the evidence. Publishing empirical evidence regarding LIFT's program outcomes would be a meaningful contribution to the evidence base.

- Economic interventions like LIFT's model may be a good approach for **preventing IPV without increasing inequity**, since annual household income was the single most important predictor of IPV across racial groups after controlling for variables such as alcohol misuse, childhood exposure to IPV, and relationship factors.

- To further increase their preventive impact on IPV, LIFT can **incorporate key evidence-informed, survivor-centered practices and policies** into their existing programs.

What now?

Because LIFT's model is a novel evidence-informed approach in the field of IPV prevention, LIFT could advance the field by disseminating their model, expanding their evaluation, and adopting procedures to more directly address the impacts of IPV among LIFT members who are survivors.

1. Provide training and technical assistance to the IPV and ACEs prevention and response field to help them learn and adopt LIFT's Theory of Change and program model;
2. Expand program evaluation to directly assess more risk and protective factors and outcomes related to IPV prevention, including through using ACES and SDOH both as proximal and distal outcomes, and disseminate the findings widely; and
3. Ensure that LIFT coaches have the training, resources, and connections to community partners to support members who are IPV survivors.

[1] Centers for Disease Control and Prevention. (2021). Adverse Childhood Experiences (ACEs). Vital signs. https://www.cdc.gov/vitalsigns/aces/index.html

Full Report

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INTRODUCTION

There is a growing consensus in the field of public health that social determinants of health (SDOH) and Adverse Childhood Experiences (ACEs) are critically important influences for myriad health problems. SDOH are the non-medical influences that affect health outcomes, such as the conditions where people live, learn, work, and play. Differences in SDOH lead to health inequities, or the unfair, avoidable differences in health outcomes between different communities. The Centers for Disease Control and Prevention (CDC) Healthy People 2030 campaign identifies the following key domains into which SDOH can be grouped: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[2] Relatedly, ACEs are potentially traumatic events that occur in childhood that can have detrimental effects on children's development and that are linked to health challenges throughout the life course, such as chronic health problems, mental illness, and substance misuse. Like SDOH, ACEs are largely non-medical and include abuse, neglect, household and family challenges, and community-level adversity such as community violence or natural disasters.[3]

Intimate partner violence (IPV) and family poverty are serious, intergenerational challenges that are both examples and products of ACEs and SDOH. The seminal CDC-Kaiser ACEs study (1998) identified IPV against the mother or stepmother as one of the 10 ACEs studied.[4] Subsequent ACEs studies have linked family poverty to ACEs, demonstrating that people who make less than $15,000 per year, people with less than a high school education, and people who are unemployed or unable to work are among the groups of people who are more likely to have experienced ACEs as children.[5] Experiencing ACEs and adverse SDOH also increase people's risk of experiencing IPV and poverty. ACEs are linked to later unemployment, low educational attainment, and substance misuse, which are risk factors for both poverty and IPV.[6,7] Social determinants of health such as low or no employment, housing instability, low educational access and quality, neighborhood crime and violence, discrimination, and poor social cohesion both lead to and are exacerbated by poverty and are all directly related to increased risk for IPV.[8,9] Breaking intergenerational cycles of poverty and IPV is a way to directly improve ACEs and SDOH, and thus to reduce a the multitude of associated poor health and social outcomes.

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[2] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.) Social Determinants of Health. Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health
[3] Centers for Disease Control and Prevention. (2021). ACEs Infographic. VetoViolence. https://vetoviolence.cdc.gov/apps/aces-infographic/home
[4] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M, Edwards, V., Koss, M. P., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse childhood experiences (ACE) study. American Journal of Preventive Medicine, 14(4), 245-58.
[5] Ibid.
[6] Ibid.
[7] Centers for Disease Control and Prevention. (2021). Risk and Protective Factors for Perpetration. Violence Prevention. https://vetoviolence.cdc.gov/apps/aces-infographic/home
[8] Ibid.
[9] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.) Social Determinants of Health Literature Summaries. Healthy People 2030. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.) Social Determinants of Health. Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries

LIFT

IPV and poverty affect far too many in the United States. According to the CDC's National Intimate Partner and Sexual Violence Survey (NISVS), over 1 in 3 women and about 1 in 3 men in the US experienced some form of IPV in their lifetime.[10] And in 2021, 37.9 million people in the United States, including 11.1 million children, were living in poverty.[11] Both IPV and poverty have detrimental effects on people's well-being, and IPV in particular often leads to social isolation. And while it is well-documented that family and neighborhood poverty increase the risks of experiencing and perpetrating IPV, this report did not identify any existing programs or efforts that work with parents to improve their families' economic stability with the explicit intergenerational aims of preventing future IPV for the parents and preventing children from ever experiencing IPV first-hand.

LIFT, Inc. is a nonprofit that is already doing the work to break generational cycles of poverty. LIFT works with parents and caregivers, who they call "members," who are experiencing poverty to help build their families' well-being, financial strength, and social connections to lift two generations at once. Their members, 99% of whom are people of color,[12] live in neighborhoods with concentrated poverty in Los Angeles, Chicago, Washington, D.C., and New York. LIFT Los Angeles originally commissioned this report to evaluate their site-specific results and, upon learning of the strong positive results of the LA site's programming, LIFT expanded the scope of this report to assess all sites nationally.

LIFT supports members' well-being, social connection, and economic stability by providing a one-on-one financial, educational, and employment coach; direct, unrestricted cash transfers of $150 per quarter for up to 24 months; and trainings, workshops, luncheons, and social events for LIFT members. LIFT coaches support members in setting long-term goals, like going back to school or securing a living wage job, and providing monthly coaching sessions that help members meet incremental milestones along the way. This process creates a reliable, personal coach-member relationship rooted in trust while increasing members' income and education and reducing stress, anxiety, and depression. Through their participation in LIFT programs, members build financial stability, self-efficacy, and social connectedness and support.

This report investigates the impacts of LIFT's economic coaching, cash transfer, and wellbeing and social connection programming on IPV prevention across two generations. Comprehensive IPV prevention efforts include primary, secondary, and tertiary prevention. Primary prevention, simply put, is stopping violence before it starts. This is accomplished by identifying the factors that make violence more or less likely to occur and engaging in efforts to improve those factors for individuals and communities. Secondary and tertiary prevention aim to reduce the adverse consequences that occur immediately and in the long term, respectively, after IPV victimization. There is considerable theoretical and practical evidence that LIFT's existing programming may prevent further IPV against parents who are survivors, as well as preventing survivors' children from ever experiencing IPV in the first place.

[10] Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M. J., & Chen, J. (2018). The national intimate partner and sexual violence survey: 2015 data brief–updated release.
[11] Creamer, J., Shrider, E. A., Burns, K., and Chen, F. (2022). Poverty in the United States: 2021. US Census Bureau, Current Population Reports. www.census.gov/content/dam/Census/library/publications/2022/demo/p60-277.pdf
[12] LIFT, Inc. (n.d.). *Our Commitment to Equity*. LIFT. https://www.whywelift.org/

LIFT

The report consists of:

- A literature review;
- Findings from quantitative analysis of LIFT surveys of program participants regarding well-being, finances, social support, and education and employment goals;
- Recommendations for future directions from IPV prevention subject matter experts.

The literature review identifies the risk and protective factors for IPV that are connected to LIFT's priority areas of economic stability, social connection, and well-being, as well as intergenerational pathways and impacts of violence. The literature review also explores the body of evidence for parent-focused interventions for two-generation IPV prevention.

The quantitative analysis of LIFT's participant surveys examines the extent to which LIFT's existing programming decreases the risk factors and increases the protective factors for IPV identified in the literature review. Although the participant surveys were not originally designed with IPV outcomes in mind, they included items that are relevant to many key risk and protective factors.

The report concludes with recommendations from subject matter experts with over two decades of experience in gender-based violence prevention and evaluation. These recommendations focus on how LIFT can disseminate their model and build capacity across fields to expand implementation of their programming model as an innovative approach to two-generation, comprehensive IPV prevention. They also identify ways to improve their programming based on a review of secondary documents and findings from previous qualitative evaluation. Finally, the recommendations suggest future directions for evaluation to continue to strengthen the evidence base supporting their program model as IPV and ACEs prevention.

Background

Definition and dynamics of IPV

The National Domestic Violence Hotline defines IPV as "a pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship."[13] Commonly described types or tactics of abuse include physical violence, psychological abuse, sexual violence, reproductive coercion, financial abuse, and stalking.[14,15] Common adverse consequences that survivors of IPV experience include fear for their safety, injury, missing at least one day of work or school, post-traumatic stress disorder symptoms, or needing housing or victim advocacy services.[16]

One in 4 female victims and just over 1 in 6 male victims first experienced IPV before age 18; almost three-quarters of female victims and over half of male victims first experienced IPV before age 25.[17] Although IPV occurs across all levels of socioeconomic status and among all cultural backgrounds,

[13] The National Domestic Violence Hotline. (2022). Understanding relationship abuse. https://www.thehotline.org/identify-abuse/understand-relationship-abuse/
[14] Love is Respect. (2022). Types of abuse. https://www.loveisrespect.org/resources/types-of-abuse/
[15] Stylianou, A. M. (2018). Economic abuse within intimate partner violence: a review of the literature. Violence and Victims, 33(1), 3-22.
[16] Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M. J., & Chen, J. (2018). The national intimate partner and sexual violence survey: 2015 data brief–updated release.
[17] Ibid.

there are disproportionately high rates of IPV among certain demographics, including sexual and gender minorities, certain racial and ethnic minority groups (including Native Americans, non-Hispanic Black women, and multiracial people), and people with physical and mental disabilities.[18]

Financial and economic abuse are particularly relevant to LIFT's work. Financial and economic abuse tactics may include limiting accessible income, withholding money needed for survival, preventing the victim from finding employment, and sabotaging the victim's employment stability and credit history.[19,20] Economic abuse occurs in as many as 94% of cases of IPV,[21] and IPV victims who experience financial control are 4.68 times more likely to also experience physical IPV than those victims who do not.[22] The economic dependence resulting from economic abuse has been consistently demonstrated to be the primary barrier victims face to attempting to leave abusive relationships.[23,24]

Economic abuse occurs in as many as

94%

of cases of IPV.

Prevention

IPV prevention efforts seek to reduce both the rates of IPV that occur in the first place and the negative outcomes that might result from IPV. Comprehensive prevention efforts include primary, secondary, and tertiary prevention. Primary prevention, simply put, is stopping violence before it starts. This is accomplished by reducing risk factors and increasing protective factors for perpetrating and experiencing IPV. Risk factors are the influences that increase the likelihood that an adverse outcome will occur, and protective factors are those that reduce that likelihood, often by creating a buffer against risk.

Secondary and tertiary prevention aim to reduce the adverse consequences that occur immediately and in the long term, respectively, after IPV victimization. Secondary prevention can include emergency and medical care, while tertiary prevention aims to address trauma, disability, and recovery from IPV.25 Because many of the adverse consequences of IPV are closely linked to risk and protective factors for IPV, secondary and tertiary prevention among survivors of IPV may have a two-generational effect by acting as primary prevention for survivors' children.

[18] Miller, E., & McCaw, B. (2019). Intimate partner violence. New England Journal of Medicine, 380(9), 850-857.
[19] Showalter, K. (2016). Women's employment and domestic violence: A review of the literature. Aggression and Violent Behavior, 31, 37-47.
[20] Durrence, A., Doyle, K., & Passi, S. (2020). Making safety affordable: Intimate partner violence is an asset-building issue. Asset Funders Network and FreeFrom. https://www.freefrom.org/wp-content/uploads/2021/06/Making-Safety-Affordable.pdf
[21] Postmus, J. L., Plummer, S.-B., McMahon, S., Murshid, N. S., & Kim, M. S. (2012). Understanding economic abuse in the lives of survivors. Journal of Interpersonal Violence, 27(3), 411–430.
[22] Showalter, 2016.
[23] Stylianou, 2018.
[24] Durrence et al., 2020.
[25] Centers for Disease Control and Prevention. (2022). *Violence prevention fundamentals.* VetoViolence. https://vetoviolence.cdc.gov/apps/main/prevention-information/47

OVERVIEW OF THE LITERATURE

This literature review explored the risk and protective factors for IPV that are connected to economic stability, social connection, and well-being, as well as intergenerational pathways and impacts of violence. The review also explored the body of evidence for parent-focused interventions for two-generation IPV prevention. Background information and key findings and takeaways are summarized in this section.

Review scope

LIFT commissioned this report to explore the extent to which existing evidence about IPV prevention supports their theory that their existing programming, which serves the mission of breaking generational cycles of poverty to lift two generations at once, may also be breaking generational cycles of IPV. LIFT's core programming involves a holistic approach that works with parents of young children to build financial capacity, personal well-being, and social connection. Program components include one-on-one financial and educational coaching; direct, unrestricted quarterly cash transfers to members; and social and educational events for member cohorts. Their work has had demonstrable impacts for their prioritized outcomes: the average LIFT family sees $63,000 in net benefits gained from improved employment opportunity and income increases – double the gains that would have been achieved without LIFT's intervention. Moreover, 65% of LIFT members reported reduced stress levels, hundreds of families attend LIFT-sponsored social events each year, and 97% of LIFT members report feeling extremely or very connected to their LIFT coach.[26]

LIFT was aware that financial stability, social connection, and well-being, in addition to being critically important outcomes on their own, are all documented as risk and/or protective factors for IPV. And, similar to the effects of poverty, IPV can have serious deleterious effects on both adults who experience it directly and their children who witness it.

Thus, the literature review aimed to:

1) identify risk and protective factors for IPV, with particular focus on those related to economic stability, social connection, and well-being;
2) Explore the intergenerational impacts of witnessing IPV as a child; and
3) Identify potential two-generation prevention pathways and interventions.

Based on LIFT's well-being survey and consultation with LIFT staff, well-being was operationalized as self-efficacy, empowerment, mental health, access to basic needs and community resources, and

[26] LIFT, Inc. (n.d.). *Impact*. LIFT. https://www.whywelift.org/

attenuated societal marginalization and substance use. The review included both quantitative and qualitative studies. Because the bodies of literature about IPV risk and protection, childhood exposure to parental IPV, and IPV prevention and intervention are extensive, only reviews, systematic reviews, and meta-analyses were included.

Key findings and takeaways

LIFT's focus areas: economic mobility, social connection, and well-being

Overall, the literature supported LIFT's theory and found numerous risk and protective factors connected to their three priority areas and to intergenerational cycles of violence. Many of the identified factors have robust evidence of strong impact on risk for IPV victimization and perpetration.

> **Critically, there is consensus in the literature that economic stress and low income are strong predictors of risk for IPV victimization and perpetration.**

This is true across racial and ethnic identities and when controlling for a variety of other factors. Economic instability, in addition to being a predictor of IPV, is also an extremely common outcome of IPV for victims, leading victims at high risk of re-exposure to violence.

Social isolation and social connection are also key themes among the risk and protective factors documented in the literature. High-quality social connection among peers, families, and communities are significant and modifiable buffers against risk. For instance, at the neighborhood level, having neighbors who do not look out for each other increases IPV risk. However, neighborhood collective efficacy protects against IPV, even in neighborhoods with high risk due to economic disadvantage.

The literature on IPV risk and protective factors also includes well-being factors both closely related to those measured in LIFT's well-being survey and beyond. Self-efficacy, healthy coping mechanisms, and self-esteem are all protective against IPV.

One review found that annual household income was the single most important predictor of IPV for white American, African American, and Latinx couples.

LIFT

More specifically, key IPV risk and protective factors related to LIFT Inc.'s intervention focus areas include:

ECONOMIC STABILITY

- Low income
- Low educational attainment
- Economic stressors like unemployment
- Neighborhood disadvantage, like concentrated poverty
- Communities with limited educational and economic opportunities
- Societal income inequality
- Protective: Accessible economic and financial help
- Protective: Access to paid parental leave among women

SOCIAL CONNECTION

- Social isolation/lack of social support
- Poor parent-child relationships
- Family conflict
- Communities where people don't know or look out for each other
- Social disorganization
- Protective: Strong social support networks and positive relationships with others
- Protective: Family support and cohesion
- Protective: Community support and connectedness

WELL-BEING

- Mental health conditions
- Heavy alcohol and drug use
- Low self-esteem
- Minority stress from societal marginalization
- Communities with easy access to drugs and alcohol
- Communities with high rates of violence and crime
- Traditional gender norms and gender inequality
- Protective: Healthy coping skills
- Protective: Access to basic needs like safe, stable housing; medical care; and mental health services

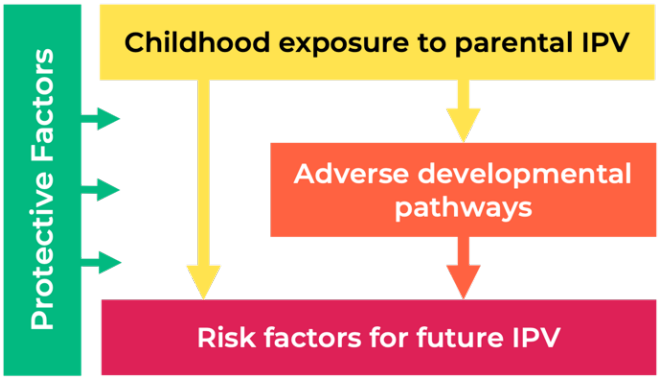
Intergenerational IPV risk and dynamics

There is also considerable evidence supporting the intergenerational nature of IPV risk, and thus the theory that a two-generation approach may be effective for IPV prevention. There is a strong consensus in the literature that witnessing or being exposed to parental IPV as a child has a low to moderate positive association with risk of experiencing or perpetrating IPV later in life. Some additional consequences of childhood exposure to parental IPV, such as increased risk for depression, conduct disorders, and acceptance of IPV, are also direct risk factors for IPV in adulthood. Furthermore, the literature describes an adverse developmental pathway that can be set off by witnessing IPV as a child. Fortunately, this pathway can be successfully disrupted by certain protective influences. It is likely that the association between exposure to parental IPV and experiencing or perpetrating IPV later in life is only low or moderate precisely because protective influences can prevent the adverse developmental pathway.

Major steps along the adverse developmental pathway that can result from childhood exposure to parental IPV include:

- Attachment issues as an infant and toddler;
- Externalizing behaviors in preschool;
- Poor social skills, experiencing or perpetrating bullying, and difficulty adhering to rules in school age; and
- Violence, delinquency, and crime in adolescence and adulthood.

However, evidence shows that many influences can protect children exposed to



parental IPV by changing or reducing this adverse pathway. Such influences include better maternal mental health, quality of parenting, parental attunement to the child's emotional experience, more social support for children, and coping skills.

Some evidence also demonstrates a dose-response effect, such that the more a child is exposed to parental IPV, the more likely they will experience adverse outcomes, including future IPV. Much of this evidence comes from more generalized studies about adverse childhood experiences (ACEs), which include child exposure to parental IPV but also several other types of childhood experiences, including economic insecurity and other ACEs that can result from economic insecurity. Some studies show that children being re-exposed to parental IPV after the survivor parent has sought help from service organizations increases negative outcomes among children. Thus, the evidence suggests that preventing parental re-exposure to IPV may be an important mechanism for preventing future IPV among exposed children.

Two-generation approaches to prevention

Most of the existing evidence demonstrating effectiveness of two-generational approaches to IPV prevention comes from programs that work with both children and parents to address individual and relational dynamics. Typical program focuses include attitudes and beliefs about gender and relationships, parenting skills and stress, and bonding between parents and children. These focuses align well with LIFT's priority areas of social connection and well-being. Many of these programs are for universal child and adolescent populations, though some are exclusively delivered to children exposed to parental IPV and their non-offending parent. While there is clear evidence that these approaches reduce risk factors and bolster protective factors, few of these programs have assessed for and demonstrated reductions in teen dating violence and other violence outcomes.

The review did not identify any studies of prevention efforts that intervened on parental or family economic mobility and assessed changes in risk or protective factors or violence outcomes among children. However, the theory behind this approach is supported by the evidence.

IPV risk is higher among economically unstable and disadvantaged families and communities. Moreover, economic abuse is extremely common and often severe in relationships characterized by IPV and compounds economic risk factors for survivors and their children. Interventions that improve economic stability may help reduce survivor parents' risk of re-exposure to IPV and reduce the family's overall economic instability, thereby reducing economic risk factors for survivors' children and potentially disrupting adverse developmental pathways for children. Additionally, supporting women's economic stability regardless of IPV experience, such as through maternity benefits, equal pay for equivalent work, and paid parental and family leave, has been theoretically linked to preventing IPV among children. This approach is theorized to have benefits for both economic stability factors and gender equity.

LIFT

Addressing inequity and societal marginalization

Any prevention strategies should consider and be responsive to risk and protective factors that relate to some of the core dynamics of IPV. One such dynamic is societal marginalization and the resulting minority stress and acculturation stress for marginalized individuals. Societal marginalization is when certain groups of people are denied access to power, resources, and opportunities. Minority stress is a heightened level of stress felt by individuals due to experiencing an environment and culture that is hostile to one's social group,[27] and acculturation stress refers to a reduction in health status that is systematically related to having to assimilate to the dominant culture.[28] Some examples of groups who are marginalized and thus experience an added burden of stress include people who are undocumented, people of color, people with limited English proficiency. All of these phenomena increase the risk for IPV and affect survivors' experiences of IPV. Because LIFT works with economically marginalized parents, 99% of whom are people of color, LIFT programming should aim to counteract societal marginalization to more successfully reduce risk for IPV.

Other core dynamics of IPV include belief in strict gender roles, dominance and control of the relationship, and one partner controlling financial and economic resources. All of these risk factors are commonly foundational to parents' IPV risk and experiences and may undermine LIFT's intervention success if not adequately addressed.

Economic interventions may be a good approach for ***preventing IPV without increasing inequity,*** since annual household income was the ***single most important predictor of IPV across racial groups*** after controlling for variables such as alcohol misuse, childhood exposure to IPV, and relationship factors.

[27] Dentato, M. P. (2012). *The minority stress perspective.* American Psychological Association. https://www.apa.org/pi/aids/resources/exchange/2012/04/minority-stress
[28] Berry, J. W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. *International Migration Review*, *21*(3), 491–511. https://doi.org/10.1177/019791838702100303

QUANTITATIVE ANALYSIS OF LIFT PROGRAM RESULTS

Background

For this report, existing data from LIFT's regular program evaluation processes were reviewed with the following new evaluation questions in mind:

1. To what extent did LIFT's programming reduce risk factors and/or increase protective factors for IPV among LIFT members?
2. To what extent did the program results identified in question 1 vary among participants by primary language spoken?
3. To what extent did the program results identified in question 1 vary among participants by race?

LIFT collects a set of surveys from members every three months. The surveys include questions related to member well-being, social support, finances, and education and employment goals.

The authors of the report cross-referenced the items asked in the well-being survey with the results of the literature review to select survey items for analysis. This report only assessed items from the well-being survey that matched the identified IPV risk and protective factors based on the criterion of face validity, i.e., which items in the survey appeared on their face to measure changes in identified risk and protective factors. This yielded the following variables:

- Benefits income
- Individual income
- Household income
- Social support (operationalized in the well-being survey using the Medical Outcomes Social Support Survey score)
- Financial well-being (operationalized in the well-being survey using the Consumer Financial Protection Bureau's Financial Wellbeing Scale score)
- Educational enrollment
- Educational attainment
- Employment

The included members at all four LIFT sites in Los Angeles, Chicago, New York, and Washington, DC. All analyses were conducted on the first and most recent data collection points for each member, meaning that members had been in the program for different lengths of time. Members who did not have both data points for the dependent variables or who were missing data for the independent variables were excluded from analysis.

LIFT

The analyses drew on data from 1001 LIFT participants. Among the participants, 916 were female and 65 were male. Five hundred and ten were Hispanic or Latino, 376 were African American or Black, 12 were Asian or Pacific Islander, 9 were mixed race, 8 identified as "Other," 8 Caucasian, and 2 Native American. Four hundred forty-four spoke Spanish as their primary language, 530 spoke English as primary language, 7 spoke French, 3 spoke Amharic, 2 spoke Chinese, 1 spoke English/Tagalog, 1 spoke Yoruba/Hausa, and 1 spoke Mandarin.

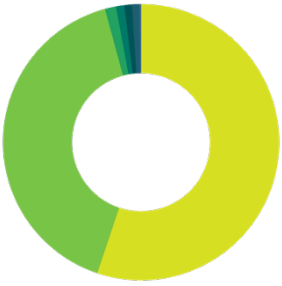
PARTICIPANT CHARACTERISTICS

Gender

| Female: 93.4%

| Male: 6.6%

Race



| Hispanic/Latino: 53.6%

| African American/Black: 40.6%

| Asian/Pacific Islander: 1.3%

| Mixed race: 0.01%

| Caucasian: 0.01%

| Other: 0.01%

| Native American: 0.002%

Primary Language

| English: 53.6%

| Spanish: 44.9%

| French: 0.07%

| Amharic: 0.02%

| Chinese: 0.02%

| English/Tagalog: 0.01%

| Yoruba/Hausa: 0.01%

| Mandarin: 0.01%

Key findings and takeaways

The analysis found that all variables assessed showed statistically significant increases from participants' first survey response to their most recent, except for changes in benefits income, which did not show any statistically significant change. Thus, as theorized, LIFT's existing programming has made significant improvements among members in risk and protective factors for IPV across LIFT's three focus areas of financial strength, well-being, and social connection.

Variables that were assessed using quantitative scores on the survey were stratified by primary language spoken and by race. In the national analysis, there were no statistically significant differences by primary language spoken or by race for individual income, household income, or

social support. There were statistically significant differences in the national analysis by race and by primary language spoken for the financial wellbeing outcome. LIFT members who speak a primary language other than English saw greater increases in their financial wellbeing than those who speak English as a primary language. Hispanic/Latinx members also saw greater increases in their financial wellbeing than did Black/African American members or members of other races. This difference is still encouraging, as Hispanic/Latinx members enter the program with lower incomes on average, and Black/African American members still saw statistically significant increases in financial wellbeing.

LIFT's programming has already demonstrated success in improving members' lives in ways that support IPV prevention, with greatest benefit to those who are marginalized on multiple axes.

Table 1. Changes Between First to Most Recent Data Point for Quantitative Variables

Variable	Overall Change *(*p < .001)*	Percent Change
Benefits income	$31.05 increase (p > .05)	7.22% increase
Individual income	$200.19 increase*	24.66% increase*
Household income	$411.95 increase*	29.51% increase*
Social support	3.04 point increase*	11.54% increase*
Financial well-being	0.74 point increase*	4.55% increase*

Table 2. Changes Between First to Most Recent Data Point for Qualitative Variables

Variable	Overall Result *(*p < .001)*
Educational enrollment	Increase*
Educational attainment	Increase*
Employment	Increase *

LIFT's programming has already demonstrated success in making changes that support IPV prevention, without any inequities by race or primary language spoken in the assessed results.

RECOMMENDATIONS AND FUTURE DIRECTIONS

The following are key recommendations for how LIFT can support the adoption of their program model as two-generation IPV prevention. More detail for each recommendation is below.

1. Build capacity for LIFT's model as IPV prevention across fields.
    a. Provide training and technical assistance on LIFT's model to IPV and ACEs prevention and response practitioners and funders.
    b. Train LIFT staff on how to better serve members who are survivors of IPV.
2. Adopt key standard operating procedures to enhance LIFT's effects on IPV prevention.
    a. Training
    b. Intake and screening
    c. Working with survivors
    d. Community resources
3. Expand evaluation of LIFT's programming with a focus on two-generation IPV prevention.
    a. Disaggregate key data points.
    b. Expand the scope of program evaluation.

Build capacity across fields.

Provide training and technical assistance to the IPV prevention and services field on how to build financial strength and why it matters for IPV, ACEs, and SDOH.

There is a strong theoretical framework that suggests that LIFT's programming model can be a successful strategy for comprehensive prevention of IPV. LIFT has demonstrated statistically significant success in improving individual and family financial strength, parental well-being, and social connection. The increases that LIFT members see in these protective factors, and the associated decreases in related risk factors, can have far-reaching, two-generation preventative effects: they can make member parents, both those who are already IPV survivors and those who have never experienced IPV, less at risk for experiencing IPV in the future. These improvements can also reduce IPV risk for LIFT members' children by increasing protective factors among their families. Economic instability is both a critical factor for risk of exposure to IPV and a key barrier for many survivors to escape from IPV. Improving family economic strength, as well as incorporating a holistic approach that includes well-being and social connection, can lead to meaningful, lasting change for parents and caregivers and their children. LIFT can help strengthen the field of IPV prevention by helping other agencies and communities integrate key components of their program approach and the lessons they have learned through implementing their model.

LIFT's relationship with funders:

LIFT should train funders of IPV prevention and response work, ACEs prevention, and SDOH improvements to support advocacy for expanding funding and support for family economic interventions. Training for funders should include information on LIFT's theory of change for IPV

prevention, evidence that supports LIFT's model as a comprehensive IPV prevention, and the benefits of a two-generation approach to prevention with regards to IPV, ACEs, and SDOH.

Trainings for funders may also benefit from comparing the innovative approach of modifying family economic strength as compared with traditional interventions that aim to prevent IPV.

- Most, if not all, of the existing empirical evidence for interventions that have been demonstrated to reduce IPV outcomes, is for curriculum-based health behavior change programs, often for youths and young adults. The curricula aim to change knowledge, attitude, and ultimately behaviors such as perpetrating violence or intervening against violence as an active bystander. However, health behaviors are notoriously difficult to change.[29] Increasing families' economic stability and strength a) directly improves SDOH and risk and protective factors for IPV without relying on individual health behavior change, and b) can help remove resource barriers to healthy behavioral decisions that can further support IPV prevention.
- LIFT's model is more than simply a cash transfer or financial literacy program for survivors. Many such programs exist, often with the goal of helping survivors heal, rather than preventing future violence across two generations. The instrumental and emotional support that LIFT members get from their coaches and from community building programming make this model more robust, as it addresses social connection and well-being in addition to economic stability. The model takes a more population-based approach than traditional economic support programs for survivors, serving community members who are at higher risk of experiencing IPV, but who have never experienced IPV. Together, these elements make the LIFT model a more "upstream," preventative approach than a traditional survivor economic support program.

In short, **programming focused on building economic stability, social connection, and well-being can have broad, sustainable impacts that can reduce adults' and children's exposure to IPV and myriad other health outcomes.** A model like LIFT's that includes building families' income, wealth, and future income capacity may be a highly impactful addition to IPV prevention funders' portfolios.

LIFT's relationship with IPV agency leadership and prevention specialists:

LIFT should provide training on their theory of change for IPV prevention and why family economic strength, well-being, and social connection matter in comprehensive prevention efforts. Training should also include the fundamentals of developing and implementing programming aligned with LIFT's model, how to build partnerships to successfully implement the model (including with funders), and how elements of LIFT's model might complement agencies' existing IPV prevention efforts.

LIFT's relationship with IPV response workers/advocates:

LIFT should train IPV survivor advocates in basic economic coaching skills and principles. LIFT has begun to offer "LIFT TA," which includes providing sector-tailored versions of LIFT's existing "Lifters in Training" five-day training series, as well as ongoing organizational support for two years. With appropriate funding, LIFT should expand their technical assistance efforts to reach IPV response

[29] Laverack, G. (2017). The challenge of behaviour change and health promotion. *Challenges 8*(2) 25. https://doi.org/10.3390/challe8020025

professionals who are interested in doing economic advocacy with survivors. This kind of expansion could help IPV agencies build more robust services for survivors and expand into comprehensive prevention even if they do not already offer prevention-specific programming.

Cross-train LIFT coaches to better serve IPV survivors.

IPV survivors are among the LIFT member cohorts, and all LIFT coaches should have basic knowledge on the dynamics of IPV and skills in serving members who are IPV survivors appropriately. The existing "Lifters in Training" three-day training series for LIFT coaches should be modified to include IPV-specific content. The Coaching Best Practices section of the training may be an ideal time to bring in external IPV subject matter experts to train LIFT coaches on, for instance:

- Basic dynamics and possible warning signs of IPV;
- Key practices for protecting survivors' confidentiality and safety from abusive partners, family members and friends, other organizations, and other parties from whom the survivor wants privacy;
- Mandatory abuse reporting requirements and best practices;
- The impacts of IPV on survivors' money management, saving, debt, credit, job stability; career advancement, educational attainment, social connection, and well-being;
- Connecting survivors to IPV services via a warm hand-off; and
- Collaborating with survivors and their IPV service providers regarding increasing survivor safety and autonomy via the coaching relationship.

As an important note, this training should **not** aim to position coaches or other LIFT staff to provide IPV-specific services, but rather to be more sensitive to IPV-related issues in their existing services. Providing official IPV response services in California involves certification trainings approved by the state government and is subject to specific laws governing confidentiality and court privilege. This report is **not** recommending that LIFT pursue these directions.

Adopt key standard operating procedures to enhance LIFT's effects on IPV prevention.

LIFT previously conducted qualitative case studies with LIFT coaches and with LIFT members who had experienced IPV. Based on the key findings from these case studies, best practices in working with survivors from IPV subject matter experts, and the theory of change presented in this report, the following recommendations could improve the impacts of LIFT's existing services for members who are IPV survivors.

Training

- Include information on IPV basics in all "Lifters in Training" series, as described in the "Provide training and technical assistance (TA) to the IPV prevention and services field on building financial strength and why it matters for IPV" section of this report.
- Provide training on IPV basics to existing LIFT coaches who have already completed "Lifters in Training."

LIFT

Intake and screening

- Create a standard operating procedure that for all LIFT members who come in with a partner, LIFT coaches should conduct a portion of the initial intake and/or Wellness Screener session separately with each partner. This would allow for a private space to disclose IPV and/or separate financial, educational, or career goals.
- Consider asking a question in the Wellness Screener, **to be asked to individual LIFT members not in the presence of their partner(s),** about experiencing IPV, including verbal, emotional, and financial abuse, in addition to physical abuse. This might reduce stigma and help members identify their experiences as IPV, given that the screening question would be universal and not targeted to each individual LIFT member specifically.

Working with survivors

Create a standard operating procedure that for any LIFT member who discloses experiencing IPV:

- Any documentation of the member's status as a survivor, including and especially safety plans, should be stored separately from any documents or materials that could be accessible to the abusive partner or any other family member.
- Any documentation of the member's status as a survivor or experiences of abuse should be kept with as little detailed information as possible, in case of documentation being subpoenaed.

Community resources

- Create a resource list for LIFT coaches to use to refer members experiencing IPV to evidence based therapeutic interventions, such as a brief dialectical behavioral therapy group.
- Partner with IPV service providers to hold community building events specifically for LIFT members who are survivors. Events can be social and/or educational.
- Connect members to resources (events, therapy, coaching, classes, etc.) that build parenting skills that have been demonstrated to reduce adverse developmental pathways for youth exposed to IPV, such as quality of parenting, parental attunement to child's emotional experience, and healthy coping skills. Examples include the Incredible Years or the Triple P parenting program. Build referral networks that support these connections.

These recommendations can help build more robust skills and resource lists for LIFT coaches to rely on in their work with LIFT members who have experienced IPV, without significantly expanding the services LIFT offers or resources LIFT needs to be successful.

Expand evaluation of LIFT's programming with a focus on two-generation IPV prevention.

This report demonstrates LIFT's positive impact on risk and protective factors for domestic violence, clearly speaking to the value LIFT has in anti-domestic violence work. Additional evaluation, accompanied by funding to support it, will enhance understanding about how and why LIFT's work is relevant to domestic violence, SDOH, and ACEs, and will allow LIFT to make programmatic shifts to optimally impact relevant risk and protective factors. The following suggestions are designed to accomplish these goals.

LIFT

Disaggregate key data points.

LIFT already has a robust data collection system that uses validated instruments and assesses a wide range of proximal outcomes. LIFT may make its data collection even more robust by shifting response options/analysis categories for two variables. Tracking education data by years of education in addition to the highest level of education attained would enable further analysis and would account for the benefit of education that does not result in an additional degree. Additionally, LIFT currently collects data based on employment and aggregates "part-time" with "temp/contract" and "self-employed" with "full-time." Disaggregating these data, or collecting additional employment data based on the number of hours worked per week, would facilitate more clear results that speak to LIFT's impact on education.

Expand the scope of program evaluation.

To strengthen the evidence on how LIFT's programming can prevent domestic violence, additional funding should be used to support development of evaluation plans and subsequent data collection and analysis in several areas. Expanded evaluation plans should focus on additional economic risk and protective factors affected by LIFT's core coaching and cash transfer programming, as well as their additional programming efforts. Evaluation expansion should also explicitly examine the impact of LIFT's work on LIFT members' children.

LIFT may strengthen the case for its impact on domestic violence by expanding the data it collects in participants' financial realities. LIFT has the potential to affect access to paid parental leave, accessibility of economic and financial help, access to basic needs, and equitable control of economic and financial resources, all of which are risk or protective factors related to domestic violence. If LIFT measures these constructs and demonstrates a positive impact, this will further bolster the case that LIFT's work can prevent domestic violence.

In addition to providing finance, education, and career coaching and direct cash payments, LIFT seeks to positively impact families through its EMPOWER Family Workshops and its fatherhood program. LIFT may consider measuring additional risk and protective factors related to this programming, such as family support and cohesion, quality of parent-child relationship, healthy coping skills, self-esteem, and minority stress. Similarly, LIFT could consider using a dose/response framework to analyze whether participants who participate in more aspects of its program see greater improvements in risk and protective factors related to domestic violence.

Finally, LIFT does not currently collect data from children, but its two-generation approach is a significant part of its theory of change. LIFT has significant potential to impact risk and protective factors for domestic violence that are related to children's wellbeing. In expanding its data collection to include constructs related to youth, LIFT should strongly consider avoiding types of data collection that could trigger a mandatory report of abuse. Instead, LIFT should consider collecting data on constructs that are closely related to IPV but would not trigger a mandatory report, such as children's coping skills and levels of social support, maternal mental health, and parental attunement. To mitigate the added data collection burden, LIFT could collect these data from parents.

CONCLUSION

Intimate partner violence, adverse childhood experiences, and social determinants of health are pervasive social challenges in the United States. Even as awareness of IPV and ACEs has increased, the field has struggled to develop effective prevention strategies. LIFT's model of cash transfers, economic mobility coaching, and events that build social connection is a promising approach to IPV prevention – among adults at risk for IPV, adults who have already experienced IPV, and youth with greater risk for future IPV due to childhood exposure. This promise is represented theoretically in LIFT's Theory of Change for Two-Generation IPV Prevention and empirically in LIFT's evaluation data. Low income and economic stress are strong predictors of IPV, and social connection is an important protective factor against IPV. Influences such as better maternal mental health, quality of parenting, parental attunement to the child's emotional experience, more social support for children, and coping skills, all risk and protective factors that LIFT could impact, may protect children exposed to IPV against increased risk for future victimization or perpetration and deleterious impacts of ACEs.

A secondary data analysis of LIFT's existing program evaluation data indicates that LIFT members see statistically significant shifts in income, social support, financial wellbeing, education, and employment. Each of these constructs has been found in peer-reviewed literature to significantly impact risk for IPV, providing support for both LIFT's theory of change and LIFT's programmatic effectiveness. And perhaps most importantly, LIFT's programming impacts risk and protective factors related to IPV without exacerbating inequities and with greatest benefit to those who are marginalized on multiple axes.

LIFT is well-positioned to further contribute to the field of IPV and ACEs prevention by:

- Conducting **additional evaluation** activities to further develop the evidence-base for its two-generation approach;
- Making minor **programmatic adjustments** to directly target additional risk factors related to IPV; and
- **Providing training and technical assistance** to relevant partners to disseminate its novel two generation approach.

Securing additional funding to support these enhancements will enable LIFT to make an important contribution to the evolving field of IPV prevention.

LIFT

ACKNOWLEDGEMENTS

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LIFT

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