



Reinvestment
PARTNERS
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REINVESTMENT PARTNERS' COMMENTS ON DRAFT IPV SERVICE DEFINITIONS

Reinvestment Partners is a nonprofit advocacy and community development corporation based in Durham. The agency is involved in neighborhood stabilization in areas that have high levels of violence. Durham County typically ranks in the top two or three counties in the violent crime rate incidents per population in North Carolina.

The Religious Coalition for a Nonviolent Durham holds vigils for murder victims. This past Friday they held a vigil is for Gregory Shaw Jr. who was shot March 7, 2019 at 923 Old Fayetteville Street. This is the third murder in 2019 within a three-block radius of our redevelopment of a historic property on Fayetteville Street. There is a geographic dynamic to the incidence of violence. In 2016, the violent crime rate in the neighborhood was 326 violent crimes within one mile. In comparison, the county average was 13 violent crimes per square mile.

The agency has focused its redevelopment efforts on those areas where there is a link between violence and disinvestment. But neighborhood redevelopment is woefully insufficient without intervening in individual lives and the culture of violence,

Reinvestment Partners is supportive of DHHS Pilot Service Definitions including robust program descriptions for a range of services that address interpersonal violence. We agree with the analysis of the *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence*, by the Centers for Disease Control and Prevention that the different forms of violence have underlying connections and often share the same root causes. Accordingly, interventions must employ a comprehensive strategy that understands the interconnectedness of violence. For a more effective comprehensive strategy, we need better coordination of interventions to reduce violence in households and in the broader community.

Case management services and assistance need to be comprehensive and encourage the program descriptions to be broad in who qualifies for assistance. For example, if relatives of those involved in a violent act as the victim or perpetrator are Medicaid beneficiaries, they should qualify for services even if the victim does not receive Medicaid.

The Pilot Services Definitions have components of a comprehensive approach. However, its focus on the individual may lead to the exclusion of community based interventions that can have a significant preventative impact.

We support Dyadic Therapy Services to reach children and parents impacted by trauma to meet immediate needs and to intervene in generational behavior and violence.

We applaud the inclusion of the IPV Case Management Services for domestic violence and hope it will be the basis for the development of center for the coordination interagency services.

The Violence Intervention Services to reduce community based violence should be implemented at a community level in high risk neighborhoods and in the hospital trauma center. The current service definitions do not include hospital based interventions, which can be critical to identifying those in need and providing services to those directly affected by violence.

These approaches need to be supported by general population initiatives such as school-based conflict resolution and anti-bullying programs. We support building resilience in the community through trainings on grief support through nonprofit and faith-based institutions. We support Restorative Justice initiatives for conflict resolution and community healing.

We believe coordination with the police and District Attorney for reforms in enforcement and sentencing will create more effective reduction of violent crimes and reduce over-policing in lesser crimes.

These non-medical interventions need to be supported as a multifaceted strategy to change the culture of violence in our community.

The existing service definitions assume that beneficiaries are identified through screening tools and do not address those individuals or families who are interacting with medical providers in crisis situations related to violence. This is a weakness of the service descriptions and there needs to be a coordinated and immediate path to services for victims of violence (and members of their household who are victimized through witnessing violence) for those Medicaid beneficiaries in crisis situations related to interpersonal violence. The literature indicates that those who would benefit from interventions and services are more receptive to receiving those services during a crisis event.

Reinvestment Partners' policy and programmatic expertise resides in housing and food domains. Therefore, we asked for assistance from the Center for Social Determinants, Risk Behaviors and Prevention Services at RTI International to respond to the North Carolina Department of Health and Human Services' (DHHS) Draft Pilot Service Definitions for Interpersonal Violence.

The Center conducts research on violence intervention programs across the nation. The Director, Phillip Graham, holds a PhD in public health with a focus on the impact of violence and trauma. We agree with the insights provided below and submit these comments to inform the service description and pricing. We encourage NC DHHS to include the Center for Social Determinants in its program design and evaluation efforts.

1. IPV Case Management Services

- a. This looks overall strong.
 - b. Linkages to child care and other social services are included, but one of the most lasting outcomes of individuals leaving an abusive relationship is the effect on youth of witnessing domestic violence. This is an Adverse Childhood Experience (ACE). While the services will be focused on the individual (the adult) leaving relationship, additional services, namely trauma-informed therapy, should be specified for the children affected by the domestic violence. Witnessing domestic violence is one of many predictors of subsequent aggressive behavior in youth, and this would be an opportunity to stop that cycle.
2. Violence Intervention Services
- a. De-escalation skills and conflict resolution in counseling should be evidence-based and part of a larger offering of options to include trauma-informed therapies such as Trauma-Focused Cognitive Behavior Therapy, Dialectical Behavior Therapy, and motivational interviewing, as youth in this pilot are likely to have already been exposed to trauma.
 - b. Peer mentors can have negative effects and increase aggression and violence, unless carefully monitored and part of a structured program. One such program which uses near peers (not same-aged peers) is the Cure Violence program, which would be recommended in this case. Similarly, an evidence-based practice such as restorative practices could also be effective. However, Cure Violence and restorative practices are often school-wide or community-wide, which could be difficult to support in this pilot model given its focus on individual intervention.
 - c. Adult mentors are likely to have a better impact than peer mentors per the research on mentoring.
 - d. School is mentioned as a setting, which is encouraged for several reasons. First, this reduces transportation and health care access barriers. Second, many peer conflicts occur in school or around school making school a great place to learn and practice de-escalation skills.
 - e. Some youth receiving these services, while community-dwelling, may have contact with the juvenile justice system. In this case, case management that interfaces with any juvenile justice case managers will be important.
 - f. Just as the individuals in IPV Case Management Services pilot will need intensive case management services, some youth in this pilot may benefit from additional case management services including housing, food, and linkages to after school programs and community engagement activities.
3. Short-term Dyadic Therapy Services
- a. The eligibility for this specifies risk for an attachment disorder, however, this is not the only indicator of risk for violence following toxic stress or adverse childhood experiences. Risk for other disorders should be considered including: Oppositional Defiant Disorder, Posttraumatic Stress Disorders, Acute Stress Disorder, and Adjustment Disorders. Mood and other anxiety disorders might be considered as well.

- b. Trauma-focused Cognitive Behavioral Therapy is one of many evidence-based therapies that goes beyond principles to actually include specific techniques and practices. Clinicians administering these treatments in this category should not only be licensed as a clinician but specifically trained in some of these complex therapies. Other potential examples include Family Check-up and Everyday Parenting, Parent-Child Interaction Therapy, Parent Management Training, and Defiant Teens.
 - c. Some evidence also supports group-based dyadic therapy, whereby youth have a group while adults have a concurrent group. These include Dialectical Behavior Therapy – Adolescent and the Coping Power Program.
- 4. Long-term Dyadic Therapy Services
 - a. Same comments from 3. The distinction between short-term and long-term seems difficult to make prior to beginning treatment.
- 5. Evidence-based Parenting Curriculum
 - a. While these services may be helpful for newly reunited families following foster care placement or parental incarceration, it is likely that in these instances, dyadic therapies under numbers 3 and 4 are more appropriate.
 - b. Other appropriate evidence-based parenting curricula include: Parenting Wisely, Staying Connected with Your Teen, and Bridges. Moreover, some of these programs can be conducted outside of a group or can be self-directed and still show efficacy.
 - c. Schools may be an appropriate setting for this.
 - d. Payment based on completion of 75% of the full curriculum may be too stringent of a bar to require. While this could be an important incentive, some literature shows that as few as 30% of parents complete a parenting program.
- 6. Home Visiting Services
 - a. Case managers should be trained in the specific curriculum they are implementing.