Justice Reinvestment Initiative: Improving Domestic Violence (DV) Responses in Rhode Island

Interventions in the Community, Incarceration, and Community Corrections

Third Presentation to the Executive Working Group
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David A. D’Amora, Senior Policy Advisor
Shanell Gist, Project Manager
Carly Mychl Murray, Senior Policy Analyst
Shundrea Trotty, Program Director
### Overview

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A data-driven approach to improve public safety, reduce corrections and related criminal justice spending, and reinvest savings in strategies that can decrease crime and reduce recidivism.

The Justice Reinvestment Initiative is supported and funded by the U.S. Department of Justice’s Office of Justice Programs, Bureau of Justice Assistance (BJA).
Project partners include staff from The Council of State Governments (CSG) Justice Center and the Rhode Island Department of Corrections.

The Council of State Governments (CSG) Justice Center is a national nonprofit, nonpartisan organization that combines the power of a membership association, serving state officials in all three branches of government, with policy and research expertise to develop strategies that increase public safety and strengthen communities.

The mission of the Rhode Island Department of Corrections (RIDOC) is to contribute to public safety by maintaining a balanced correctional system of institutional and community programs that provide a range of custodial options, supervision, and rehabilitative services in order to facilitate successful reentry into the community upon release.
The assessment phase of the project is nearly complete.
Our analysis using Sequential Intercept Mapping concludes with Intercepts 3 and 4.

Intercept 0: Community Services
May involve victim advocacy, safety resources, housing, prevention efforts, or community supports.

Intercept 1: Law Enforcement and Child Welfare
May involve arrest, referral to victims’ services, or services for children.

Intercept 2: Initial Detention and Court Hearings
May involve pre-arraignment reporting (including lethality and risk assessments or screenings), initial hearings, possible protective orders or disarmament, pretrial programming, release decisions and stipulations, or compensation.

Intercept 3: Interventions in the Community
May involve incarceration in jail or prison, mental health and substance use assessments, community treatment programs, or Batterer Intervention Programming (BIP).

Intercept 4: Reentry and Community Corrections
May involve transition planning, including compliance requirements and appropriate referrals, victim notification services, or safety planning as well as community-based supervision, such as probation or parole, community treatment programs, or domestic violence advocacy services.

SAMHSA’s Gains Center, The Sequential Intercept Model (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019). Sequential Intercept Mapping was adopted from SAMHSA’s Gains Center Sequential Intercept Model.
Recap and Updates on Presentation 2

Law Enforcement and Child Welfare Responses to DV

Court Responses to DV

Victim and Survivor Experiences with Law Enforcement and the Courts

Updates from the Judiciary and Office of the Attorney General
An analysis of law enforcement responses to DV highlighted the prevalence of officer identified DV in the state, as well as DV training requirements for law enforcement.

In Rhode Island, an average of about 7,860 DV incidents are reported to police annually. In nearly half of cases (48 percent) each year, the victim was physically assaulted.

All municipal police department recruits undergo 12 hours of training created by the VAWA Law Enforcement Domestic Violence/Sexual Assault Training Curriculum Committee.

- The curriculum is comprehensive, addressing DV and trauma dynamics, Rhode Island laws related to DV, statutory requirements for law enforcement, barriers for victims and survivors, best practices for responding to DV, assessing lethality, and resources for victims. The curriculum is interactive, involving both reading material and role-playing, and has specific sections related to lethality risks.

- Most police (90 percent) reported that they felt prepared to respond to their first DV call based on the training they received.

- The curriculum could benefit from enhanced discussion of law enforcement involvement in domestic violence, issues of immigration, interacting with Deaf/Hard of Hearing or non-English speakers, issues of bias, responding to individuals who have disabilities, and working with individuals who identify as LGBTQ+.

The analysis also highlighted experiences of law enforcement officers who respond to DV.

23 investigators with the Department for Children, Youth, and Families responded to a survey about their DV training, protocols, procedures, and perceptions.

A quantitative analysis of court data described DV cases moving through the judiciary.

Entities within the legal system also detailed their experiences with responding to DV and barriers to access.
Directly impacted victims and survivors provided their feedback on law enforcement, child welfare, and court responses to DV.

Victims and survivors reported varying experiences with law enforcement.

- Victims and survivors said that sometimes they felt supported, while other times they reported that they felt law enforcement did not help.
- Several victims and survivors reported that after calling law enforcement for support, they were told by officers to do more to prevent the violence.
- Victims and survivors reported calling law enforcement for safety only to find out the law enforcement officer is friends with the person causing harm.
- Victims and survivors reported a need for improved officer training to have more consistent responses, and so that officers can recognize signs of domestic violence that aren’t physical.
- Advocates working with law enforcement are vital to feelings of safety; however, victims and survivors reported there are not enough advocates.

Victims and survivors experienced a lack of consistency in court responses and overall struggles navigating the court system.

- Victims and survivors reported disconnects between family and district courts. Certain stipulations of family court, such as mediation encouraging co-parenting, directly contradicted conditions of district court related to no contact.
- Inconsistent experiences were reported in interacting with judges.
- Overall, victims and survivors reported that the court system was confusing and that they typically did not know their rights or what was going to take place.
- Victims and survivors also reported errors of confidentiality in which their contact information was inadvertently included on documents sent to the person causing harm.
- Court was cited by many victims and survivors as a form of continued abuse. Litigation abuse is not unique to Rhode Island and utilizes the legal process to harass victims and survivors.
CSG Justice Center staff have been able to hear from members of the judiciary and the Attorney General’s Office’s Special Victims Unit (SVU).

Members of the judiciary reported that a substantial portion of cases are related to DV. Though judges attend national trainings or seminars related to DV, standardized DV education is not required.

Attorneys with SVU reported an increase in DV cases since COVID-19 and high rates of recidivism among people with DV offenses. Critical case review committee meetings between probation, parole, and SVU were cited as helpful for building collaboration, communication, and coordination of services.

Batterers Intervention Programming (BIP) is not seen as effective for all people, as individuals have varying levels of risk and need and may cycle through classes multiple times. Other options for treatment are limited.

Judges and attorneys reported challenges in working with victims, such as fear of engaging with the court system, financial dependence on the person who harmed them, or a desire to not pursue charges against the person who harmed them. They also underscored the importance of victim advocates in supporting victims and survivors through resource provision, explanation of the legal system, and informally monitoring the safety of the victim.
Before we move forward,

what **lingering questions or comments** do you have about our last presentation or updates from the judiciary?
Intercept 3: Interventions in the Community

- Treatment Interventions
- Stakeholders Involved
- Programming: Investments, Components, and Accessibility
- Oversight and Measuring Outcomes
- Collaboration and Partnerships
Treatment interventions in the community provide vital treatment to individuals seeking help for DV victimization and perpetration.

Accountability programming for individuals who have committed DV has been provided on a national scale since the 1980s. **Early models**, including the Duluth Model, **emphasize punishment as accountability** and men’s violence being a product of society. It is important to note that **when people receive DV treatment, it is typically following a history of committing violence**.

**Results of accountability programs**, known in Rhode Island as Batterers Intervention Programming (BIP), are **mixed at best**. Such programming is **based on an outdated concept** from over 40 years ago. Best practices for successful programming integrate consistent standards for curriculum creation, implementation, and evaluation and differentiation of programming based on levels of risk and need.

Interventions in the community also **respond to issues of behavioral health (BH)**, including substance use, which national research suggests often intersect with issues of **DV**. Interventions in the community also **support victims and survivors** who have been impacted by histories of trauma.

For Intercept 3, we connected with stakeholders to understand interventions in the community for DV.

Interviews and Focus Groups

- Batterers Intervention Programming
- Center for Health and Justice
- Community health agencies
- Department of Behavioral Healthcare, Developmental Disabilities & Hospitals
- Department for Human Services
- Health Equity Zones
- Rhode Island Coalition to End Homelessness
- Veteran’s Administration

The analysis sought to assess programming, outcome measurement, and collaborations and partnerships.
Several barriers exist to accessing BIPs.

Currently, BIP is required by statute for anyone convicted of a DV offense.

The cost of BIP is prohibitive for many participants, who are often experiencing intersecting issues of homelessness, lack of social support, job instability, and difficulties meeting other basic needs.

BIP programs are all self-paid, and sliding scale services are discretionary by provider, creating significant access barriers and unequal treatment.

The utilization of the term “batterers” in programming is seen as stigmatizing.

Some BIP programs have had to consolidate or close, and most remaining programs are providing insufficient treatment responses because of a lack of resources and limited funding.
Programs are limited in the types of targeted services they can provide.

Programs lack the infrastructure and capacity to provide comprehensive risk and need based programming.

Programs lack the infrastructure and capacity to provide demographically specific programming, including for individuals in the LGBTQ+ community or classes for individuals other than men. Men, women, and gender-diverse individuals are all in the same classes.

Individuals who do not speak English, who are Deaf or Hard of Hearing, or face other language barriers have even more limited options for treatment programming. Due to the lack of resources, there are also few programs provided in languages other than English.
A lack of state investment in, and oversight of, BIPs contributes to programming that is not based on best practices.

- There is no differentiation among clients based on level of risk and need, age, number of prior offenses, nature and severity of the offense, or any previous treatment failure.
- There is no programming specific to clients who have committed general family violence rather than intimate partner violence.
- There is no consistent curriculum utilized across programs, contributing to extreme variation in programming content and adherence to best practices.
There is no standardized DV protocol for BH treatment providers, including training, assessments, or programming components.

Many BH treatment providers recognize co-occurring behavioral health and substance use disorders as well as issues related to violent victimization and perpetration but do not have capacity to provide targeted programming in BH centers.

DV training varies between BIP and BH providers.

There are no standardized risk and need assessments used for BIPs.
Lengthy waitlists for community behavioral health services create barriers.

This is especially true for individuals who cannot successfully complete a BIP program without receiving adequate behavioral health care.

Many individuals face further barriers in completing BIP if they have significant BH concerns. Because of significant turnover in BH providers, institutional knowledge about policies, practices, and partnerships is limited.
Oversight and Measuring Outcomes

Programs vary in how, or whether, they measure success beyond program completion.

BIP process and outcome data is unclear, and it is difficult to accurately track how many individuals repeat classes.

Despite overlapping issues of DV and BH, providers do not have shared metrics for measuring and reporting DV and lack a common database. It is thus impossible to operationalize and measure what success looks like beyond program completion.

There is no statewide repository for data related to DV arrests, diversions, convictions, treatment, or recidivism of people who have committed DV offenses.

It is also unclear how participant feedback impacts BIP and BH programming, if at all.

While some BH providers have patients on advisory boards or conduct community needs assessments to determine programming needs, not all do so. Therefore, some programs are more responsive to need than others.
The members of the Batterers Intervention Programs Oversight Committee (BIPSOC) are tasked with certifying programs without adequate resources or training to do so.

It is not required that any member of BIPSOC has a clinical licensure or specialized training and experience in program evaluation.

As such, members of BIPSOC do their best to evaluate and shape programming without adequate training, support, or resources.
Collaboration and Partnerships

There is limited to no information sharing between BH and BIP providers.

Clinical treatment providers do not collect the same information related to DV, if they collect any at all. The prevalence of individuals seeking BH services who also have been impacted by DV is unclear.

Information sharing practices are also inconsistent between treatment providers, the judiciary, and the Rhode Island Department of Corrections (RIDOC).

Inconsistent information sharing practices impact individuals receiving services, including victims and survivors and individuals seeking treatment for DV perpetration. Individuals are sometimes forced to disclose trauma multiple times to different providers and may struggle to receive cohesive, accessible treatment.
Investment in community behavioral health varies geographically and is contingent on buy-in from local government, creating disparate responses and unequal protection for victims and survivors of violence.

Intersecting issues of BH needs and homelessness often impact victims and survivors. Though collaboration between homeless service providers and BH providers is present in some areas of the state, this is inconsistent and leads to geographic disparities in access to care.

Health Equity Zones (HEZ) exist across the state to increase coordination between community- and systems-based partners. HEZ offers an opportunity to troubleshoot community responses to pressing health issues across Rhode Island; however, each HEZ is different in scope, goals, and impact, and they do not often communicate with one another.

The Certified Community Behavioral Health Clinics (CCBHC) grant, with funding of $25,500,000 from the American Rescue Plan Act, seeks to expand access for Rhode Islanders to integrated BH services. The model emphasizes interagency collaboration and utilizes a national set of standards for comprehensive BH care. It is unclear how intersecting issues of DV will factor into this plan.
Intercept 4: Incarceration and Community Corrections

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National data supports the importance of community supervision and reentry for individuals who have been convicted of DV as well as victims and survivors.

Most individuals with DV offenses are released under community supervision either following or in lieu of incarceration.

National research supports the benefits of community supervision programs targeting support and programming for individuals with DV offenses, including reduced recidivism and victim and survivor satisfaction.

Incarceration and reentry are also important in an interdisciplinary coordinated community response to DV, as these systems provide treatment and monitor criminal legal accountability.

For Intercept 4, we analyzed thousands of RIDOC data files and engaged stakeholders from across the RIDOC.

Stakeholders included representatives from:

- Classification services
- Clinical services
- Data management
- Probation and parole
- Transitional planning
- Victims services

Data Files

- RIDOC incarcerated and supervision population from 2015 to 2020 (Analysis forthcoming)
Probation and parole officers could benefit from a more robust DV training curriculum.

Officers receive basic training related to the definition of DV, dynamics of abuse, applicable statutes, and typical characteristics of individuals who have perpetrated DV offenses. There are no ongoing coaching or training opportunities required.

Officer training could benefit from more interactive content, role playing, and opportunities for troubleshooting issues and questions. Officers cited a need for increased education related to strategies for working with individuals who exhibit controlling, violent, and/or manipulative behavior.

Officers do not receive standardized training on working with DV victims and survivors, though all officers with a DV-specific caseload reported having had contact with DV victims and survivors.

Standardized DV training and education does not exist for RIDOC staff beyond probation and parole, such as facility correctional officers.
DV-specific probation and parole officers are challenged by caseloads with varying access to resources.

DV-specific probation and parole officers report caseloads often exceeding 100 clients. Several probation and parole supervisors estimated that DV caseload sizes surpass general caseload sizes.

The RIDOC Reentry Services unit has worked hard to create support for individuals exiting RIDOC facilities to community supervision, but further support is needed. Many individuals exiting RIDOC facilities struggle with food insecurity, have limited transportation, and/or are at risk of homelessness.

Resources available for officers to provide to individuals related to basic needs (housing, clothing, transit, etc.), as well as employment, BH, and BIP vary extensively by geographic location.
Resources are limited for individuals who have committed and/or experienced DV and are incarcerated.

It is estimated that over 90 percent of incarcerated women have experienced some form of DV; however, programming and facility infrastructure is lacking for women. Women typically do not have access to educational or supportive programming due to limited funding for curriculum and a lack of space to deliver the programming.

Women experiencing BH concerns may be placed in solitary confinement due to a lack of appropriate BH staffing and housing resources. Such practices exacerbate trauma and further experiences of victimization.

Individuals with high levels of BH and other programming needs are prioritized in resource allocation, in line with Risk, Need, and Responsivity principles. However, due to limited resources, this often leaves individuals with lower levels of risk and need without access to BH, psychoeducational, and other programming resources.

Though BIP programming for individuals who are incarcerated is available at the men’s facility, capacity is limited, and an individual is likely ineligible for BIP classes if their sentence is less than the 26 weeks (about 6 months) required by statute for the course.
DV-specific assessments are not conducted in RIDOC facilities, which can impact assessed levels of risk and need.

While the Level of Service Case Management Inventory (LS/CMI) is used to assess general criminogenic risk and need factors, no DV-specific assessments, such as the Domestic Violence Screening Instrument – Revised (DVSI-R), the Lethality Assessment, or the Spousal Assault Risk Assessment (SARA), are conducted within RIDOC.

While the LS/CMI is an excellent tool to determine programming needs, without DV-specific assessments, probation and parole officers are limited in their ability to ascertain an individual’s lethality risk, the potential to commit extreme harm, or dynamics of violence that may impact recidivism.

In addition, there is limited BH assessment, though a high percentage of people who commit DV have co-occurring BH issues.
There is considerable inconsistency regarding the treatment of BIP mandates.

Judges do not always order BIP programming as designated by statute.

Stakeholders reported that individuals may be ordered to fewer classes than required by statute.

Stakeholders also reported that individuals with DV offenses are often ordered to take the same classes repeatedly despite ongoing recidivism, indicating the lack of effectiveness of the programming.
**Departments within RIDOC and community responses to DV are siloed.**

This challenges the provision of support and resources to victims and survivors as well as to individuals seeking treatment for committing DV.

DV-specific probation and parole officers are limited in their opportunities to collaborate on issues impacting the people they supervise.

There are ongoing complications between RIDOC and the judiciary regarding communication between the agencies, the roles and responsibilities of supervision officers, and a lack of shared vision regarding the rehabilitation of those who have committed DV.

Individuals with severe BH needs are often housed in RIDOC prior to competency evaluations, though RIDOC is unable to provide responsive, targeted resources for this population. Stakeholders also reported concerns about individuals who are sentenced to serve time in RIDOC whose BH needs exceed the resources available.

There is a lack of communication between the Office of the Attorney General and RIDOC about information on restraining and no contact orders, which creates barriers for reentry planning and supervision compliance.
Without a current victim advocate position in RIDOC, staff are challenged to meet the needs of victims and survivors.

A historical lack of investment led to a reduction in the number of victim advocate positions within RIDOC, and the one remaining victim advocate recently left the position. Efforts are underway to fill this position, but the vacancy was cited as a major issue by all DOC staff interviewed.

RIDOC staff do not receive any specific training on working with victims and survivors; thus, it can be challenging for staff to know what to disclose to victims and survivors and how to best support them.
Next Steps: Preparing for Recommendations

Key Themes
Thoughts and Considerations
Next Meeting
We have identified several key themes across intercepts in our analysis of Rhode Island’s DV responses.

1. **DV-specific training and education** varies within and across intercepts.

2. Inconsistent practices of **data collection, reporting, and utilization** within and across intercepts challenge a true understanding of DV prevalence and case demographics.

3. Fluctuating and inadequate **resource allocation** for DV services creates gaps in care, particularly for demographically specific populations such as those who are Deaf and/or Hard of Hearing, do not speak English as their first language, are immigrants or refugees, have physical disabilities, or are LGBTQ+.

4. **Programming** components of DV responses do not consistently adhere to best or promising practices.

5. Gaps and challenges in **partnerships** within and across intercepts create barriers to a coordinated community response.

6. Current responses do not account for the **safety** of all victims and survivors, particularly for those individuals from demographically specific communities who face barriers to accessing and receiving services.
As Executive Working Group members, your thoughts on identified themes and considerations for recommendations are vital as we enter implementation.

- What do you see as top priorities for change?
- Where do you foresee barriers to implementing and measuring change?
- What else do we need to keep in mind that we haven’t talked about?
The next presentation in May will focus on recommendations.

In May 2023, we will come together as a group to discuss proposed recommendations based on the systems analysis.

Following the presentation of recommendations, members of the EWG will decide which recommendations to adopt and discuss priorities for implementation.

CSG Justice Center staff will be in touch with each member of the EWG to discuss recommendations prior to the next meeting. If you have not already scheduled a meeting to discuss this, please look for an invite in your inbox.
Thank You!

Join our distribution list to receive updates and announcements:

https://csgjusticecenter.org/resources/newsletters/

For more information, please contact Carly Murray cmurray@csg.org

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