Tri-County Batterer Intervention Provider Network Meeting Minutes July 8th, 2014

Attendance: Katherine Stansbury (Eastside Concern), Chris Huffine (Allies in Change), Matt Johnston (Domestic Violence Safe Dialogue), Curt St. Denis (Allies in Change), Linda Castaneda (Manley Interventions), Allyn Bradley (Clackamas Women's Services), Jennifer Hopkinson (Clackamas Women's Services), Wendy Viola (Portland State University), Chuck Murdock (Bridges 2 Safety), Phil Broyles (Teras), John Connelly (Eastside Concerns), Jacquie Pancoast (Eastside Concerns), Regina Rosann (ARMS)

Minutes by Wendy Viola, edited by Chris Huffine

Topic: Risk-informed treatment planning, presentation by Curt St. Denis

Curt will do a more expanded version of this presentation during the advanced training at Allies in Change in October. He also recommends presentations and literature by Stephen Hart, who has spearheaded the development of a number of risk assessment tools. Much of the content listed below was generated by Curt, but is also includes comments and input from other people who were present. Please refer to the attached hand-out for Curt's full presentation.

The current presentation focuses on assessing risk for perpetrating physical intimate partner violence and associated characteristics of male perpetrators that contribute to their risk. Broadly, risk assessment aims to assess the likelihood that someone will engage in violence, and to enable the development of a plan to prevent it. The goal of risk assessment is to determine a perpetrator's true risk, or their risk for perpetrating physical violence given all of the information that he, his partner, and corrections could possibly provide. A combination of static, dynamic, and acute risk factors are assessed to get as close as possible to a perpetrator's true risk and to inform appropriate treatment planning. Assessing risk is essentially looking at the world through "shit-colored glasses"—where are the potential problems and pitfalls that can lead to further bad behavior?

The risk assessment model was developed with the intention of creating groups of offenders with similar needs, who would benefit from different forms of treatment. For example, people who are low-risk tend to self-correct when they get close to offending, and by over-treating them, you can potentially damage their motivation to do so. If you keep returning to the same issues with this group, you can increase their resentment, shame, and the "fuck-it's," or the belief that they've already done everything that they can do and there is no point in continuing to try.
Creating groups of offenders based on their needs enables group facilitators to address those needs, which may be causal or co-occurring mental health needs, personality disorders, etc., as best as possible. While you could separate offenders by their risk only, or by their need only, it's ideal to group them based on both. Responsivity refers to matching the offender's treatment to their needs. *The psychology of criminal conduct,* which is now in its 5th edition, is the textbook on the risk-needs-responsivity model.

Men have the highest risk of offending when they're in their early 20's, and their risk declines from there. Having three documented offenses is also indicative of very high risk, as is the presence of multiple violations within a single year.

Across all domains of intervention, participants tend to fall into three groups. One group is very resistant, even if their life depends upon the intervention. The second group will take to the intervention for a little while before giving it up. The third group tends to take quickly to an intervention and stick with it. Working with the second of these groups necessitates the most skill and benefits the most from collaboration. Providers are encouraged to work with this group to help them understand their own risk.

No two people's risk scores mean the same thing: one person's risk score of 10 may represent an increase in their risk, while another person's risk score of 10 may be a decline in their level of risk. It's important to consider the specific risk factors that contribute to an individual's score, their risk of doing the same thing that they've done previously, and their risk of doing something worse than they've done before.

There are over 40 tools for assessing domestic violence risk, but across these tools, about 80% of the items are the same. They all include a mix of static, dynamic, and acute risk factors, including age, gender, prior DV history, generalized violence, and parole and probation violations, which are included on almost every tool.

Static risk factors are those features that people can't change. These are the most accurate factors in predicting risk. Dynamic risk factors are characteristics that can and do change, and which can be addressed in treatment, including life changes and substance use (though a *history* of substance use may be considered a static risk factor). Attitudes about women, crime, and violence are difficult to assess, and it's unclear which are most dangerous for which individuals, but can be important dynamic risk factors. Acute risk factors are the most imminent risk factors, and include victims' perceptions of danger and offenders' emotional collapse (characterized by the belief that things are bad and are not going to get better, which can translate into doing something extreme, for example, perpetrating a murder-suicide). All of these risk factors help us refine our perceptions of risk to increase our efficacy.

Risk-oriented treatment planning involves continually assessing risk throughout your relationship with a client (i.e. asking them during each visit to report all conflicts that they have had since the last time and the intensity of those conflicts, so that you're aware of these evolving risk factors). Being mindfully aware of changing risk factors enables timely and appropriate responses to them. There's always a risk that participants will do something more severe than what they've already done and it is important to break through their denial so that they acknowledge this possibility and consider the things that make it more likely. An area of continued tension is the requirement of BIPs to disclose to PO's if offenders have violated their probation. Because clients know that programs have to tell PO's, they don't disclose some acute

risks to providers. However, by lying to providers about acute risks, clients still draw their own attention to their use of these behaviors.

It's especially important to do preventive work, so that clients catch themselves before they slip into these acute risk factors, by encouraging them to think about why they start engaging in these behaviors and why they might be risky for them. It's about us teaching the guys how to manage their own risk. Risk assessment is more than practitioners reducing clients' risk, but teaching clients to identify for themselves when their risk starts increasing, and to continue doing so throughout their lives. We're also seeing clients' network members monitoring clients' risk factors, and we can direct clients' attention to network members who try to help keep them in line and keep their risk minimal. Within group, we can address risk by saying things like "that sounds risky to me," to point out risk factors for clients. Clients' safety planning can involve driving by jail or prison to remind them of what it was like to be in there and deter themselves from further offending. We can also do risk management in the first part of group, following check-ins, and encourage clients to sustain a healthy level of self-care.

Current thinking about risk assessment acknowledges that it evolves, and that risk assessment is an ongoing process. One important practice is how programs monitor current behaviors. Some programs, like Allies in Change, use "journals". Other programs have some sort of a checking in process or a client update process. The intent of the journal is to draw clients' attention to real-life concrete situations and their thoughts, feelings, and behaviors therein, through the lens of the programs, and therefore corresponding to risk factors. The journals also provide insight for providers about things in clients' lives that they wouldn't otherwise pick up on.

Providers might be able to introduce the topic of risk by encouraging clients to think about "what puts you at risk of losing your job?." You can bring the language of risk into contexts that clients care about, for example, the risk of losing their job or losing friendships. You can start by talking about the risk of clients losing what they want, and then move on to discuss the risk of harming others.

All of this information implies long-term work: until clients can acknowledge that they are abusive and that they don't want to be abusive, you can't train them to think about their own risk factors for becoming abusive. Clients usually don't start benefitting from this information until they're at least 6 months into the program. However, the more you engage in ongoing risk assessment, the more it becomes an avenue for clients to think about themselves, because it's a way of looking towards the future (i.e., "while you can't undo what you did in the past, you can certainly avoid being abusive in the future, so how might you prevent yourself from doing that?").

Contrary to many aspects of working with abusive men, there is a lot of clear empirical support and evidence based practices for effective risk assessment. However, incorporating risk assessment as an on-going part of doing this work is still rare and controversial. At present there tends to be a more heavy focus on the past (e.g., reporting on past abuse, being accountable for

past abuse, considering how past abuse has hurt loved ones) than attention to the future (e.g., what can you do differently going forward, what are your current risk factors and how do you manage them?). On-going risk assessment and risk informed treatment planning reflects more sophisticated and savvy work around denial, but on the surface, there seems to be minimal talk about accountability, abuse, how you've harmed others, empathy, etc., which challenges our beliefs about how people change. The "old school" thought is that people change by being challenged and shamed about their prior behavior--*Psychology of Criminal Conduct* is a good read on the topic.

Another important, and developing, aspect of risk assessment is identifying protective factors. Protective factors refer to things that help lower risk. Having pro-social peers and a job one truly enjoys are examples of protective factors. We can also use the language of risk to discuss positive outcomes, for example, skills and behaviors that clients can use to increase their risk for having a healthy relationship. Both risk and protective factors are weighted to reflect their ability to predict future offenses. The protective factors are scattered throughout the literature, we don't know of a unified list of protective factors, but many risk assessment tools also include them. However, these tend to correspond to more generalized recidivism, as opposed to DV-specific, but many of them apply across fields (symptom management, social support, generally relational and self-care oriented behaviors).