Tri-County Batterer Intervention Provider Network Meeting Minutes May 9, **2017**

Present: Chris Huffine (Allies in Change), Rebecca O'Shea (Pathfinders), Amy Simpson (Eastside Concern), Paulette Schmid (Home Free), Karla Upton (Multnomah County Department of Community Justice), Laura Ritchie (Multnomah County Department of Community Justice), Sarah Van Dyke (Children, Youth, & Families-Clackamas County), Shannon Barkley (Clackamas County Parole & Probation), Brent Taylor (Clackamas County Parole & Probation), Guadalupe Aragon (Grace on You), Alison Dunfee (Pathfinders of Oregon), Sierra Dishon (intern, Multnomah County Court), Kate Sackett (Portland State University)

Minutes by Kate Sackett, edited by Chris Huffine

Discussion Topic: Under-funding of programs that work with abusive partners (financial challenges of doing this work and how work is compromised by under-funding)

Diana Groener gave a presentation on domestic violence versus sexual offending, a (Western-centric, heterocentric) history of these fields, the current status of the fields, and their future directions. Compared to the batterer intervention field, the sex offender and substance abuse fields are much more well-established (e.g., in terms of their conferencing). Diana started working in DV men's groups in 1997 after working on a sexual assault crisis team. She also works in the sex offending field and has a private practice. She has also started working with and developing a treatment manual for working with psychopathic sex offenders and extremely severe forms of violence.

Domestic violence dates back to laws that sanctioned it with no limitations from 4000 years ago, which were not questioned for 3000 years. In the 1600s, laws clarified that husbands could use force against their wives or children but not kill them as a result of domestic violence. Maryland was the first US state to have a law against wife abuse in 1882, but even once domestic laws were passed in other states they were rarely enforced.

Laws that have guided sexual behavior have come mainly from moral or religious standpoints (e.g., sodomy) that considered sexual behavior to be a private thing. Every culture had variations on what was considered acceptable sexual behavior, in contrast to domestic violence which was widely acceptable and public. Sexual violence was publicized in the 1870s as a dangerous issue facing the public by strangers because of Jack the Ripper's notoriety. This behavior was no longer considered private and instead was considered a violence that evil men should be arrested and punished for. Sexuality was first studied scientifically in the 1950s (e.g., Kinsey report, Masters and Johnson) and some began to suggest that sexual violence was a mental health issue. The intervention focus was still on locking people up but to get them treatment for their sexuality, not send them to prison.

Domestic violence was widely perceived as a private matter, not as a criminal or mental health issue, through the 1960s. In the 1970s, Americans started having an overt, public conversation that sexual abuse and domestic violence are wrong. The second-wave feminist movement and victim advocates movement gained momentum and pornography was blamed as a source of violence. This led to obscenity laws and pornography laws and made allies between advocates and religious groups, mixing religious and moral issues with criminal and mental health issues.

The first rape crisis hotline opened in Washington, DC in 1972. The first women's shelter for battered women opened in 1973. The Adam Walsh Act and the center for missing and exploited children passed in the 1980s, which influenced public perceptions of sex offenders as evil criminals who needed to be locked up. A wave of high-punishment, criminal response to social problems in the 1980s combined with this to focus on sexual crimes against children as clearly unacceptable. However, physical and sexual assault of wives was not perceived to be as significant of a problem or in need of intervention.

The conversation around domestic violence became pretty strongly anti-offender and somewhat divisive in the 1990s. For example, any views that dissented from those within the advocacy movement were often seen as ill-informed and pro-offender and any resources or treatment going toward offenders was seen as taking resources away from victims. The Family Violence Prevention and Services Act was first authorized in 1994, which spread services through public awareness campaigns and began to address public housing and substance abuse issue among victims. No such laws or acts were passed in the U.S. providing support for intervention with abusive partners.

The sex offender and domestic violence fields have been developed very differently. The sex offender field's development was very top-down, driven by theory and research, and designed by judges, professionals, and clinicians. Goals focused on trying to reduce the behavior, get offenders arrested, and then intervene with the offender. The domestic violence field's development was more bottom-up/grassroots-led, in which victims became the leaders of the field, running programs and working with Congress to get more funding. Goals focused on self-defense, restraining orders, and divorce laws. Prevention became focused on helping the victim and giving her strength to get away from him and advocates saw the arrest of DV offenders as primarily a victim safety issue. Whereas the sex offender field defined community safety as incarcerating and *treating* sex offenders, the domestic violence field defined community safety as primarily helping victims flee and become safe by being separate from and that only incarceration was needed to deal with offenders.

The subsequent paths that the fields took have also developed very differently, with different standards for the work. Sex offender work is seen as treatment, so to be a clinical sex offender therapist you need to have at least a Masters degree in psychology, be licensed (involving 2000

hours of work), and have ongoing continuing education hours to keep the license current. Clients are not referred to agencies unless they are certified as sex offender treatment providers.

Domestic violence work does not have the same education or licensing requirements, as providers are required to have 40 hours of training, but standards are not enforced in many states for intervention programs. Many within the DV field are adamant that intervening with abusive partners is *not* therapy or therapeutic work and there has been widespread resistance to creating any sort of certification or licensing process.

Information is also shared differently in the fields, for example through different kinds of conferences. The Association for the Treatment of Sexual Abuse (ATSA) began in the 1980s in Beaverton, OR, initially through brown bag meetings of treatment providers, lawyers, and advocates who were thinking of how they wanted to do sex offender work. ATSA incorporated in 1985, began hosting conferences in 1987, and is now an international organization that has set standards and practice guidelines for providers, continues to host an annual conference, has a peer-reviewed journal, supports research, offers CEUs and other trainings, and gives grants for research. ATSA's current focus is on prevention and education.

There are no national conferences for DV work on the same level as ATSA's conference, and many states don't have statewide associations. This Tri-County group has mixed attendance, so it is difficult to coordinate locally as well. Most people doing this work are in very small organizations of 1-2 people or work larger agencies that are funded by other issues (e.g., substance abuse work). One issue in requiring providers to comply with the standards is that they cannot afford to (e.g., they cannot afford the loss of time to go to meetings or training or the lost travel time) and there is little funding to support these requirements. There have been modest attempts to start national BIP associations with, at best, limited success. Likewise, there have rarely been national BIP conferences and when they are held they typically have modest attendance, only a fraction of what ATSA conferences attract.

Likewise, there are no national associations or resources for DV perpetrators. For example, the Domestic Violence Resource Network is a nationally funded group, including three culturally-specific groups, and the national domestic violence hotline, but this organization is focused primarily, almost exclusively, on victims.

Improvements could start with enforcing the standards we already have, such as the 40 hours of training required for providers, coordinating information between BIP providers and POs to work more closely together, doing program intakes with police reports and collateral information to better identify client's treatment and risk needs, using risk assessment tools, shifting from intervention to more individualized treatment models, recognizing that treatment needs to be open-ended (from months to years), and bringing in other coordinated services to support individuals through the change process. If DV offenders are similar to the general offending

population, providers could also bring tools that are known to work in the general criminology field to this work (e.g., risk need responsivitiy principles, addressing the 8 criminogenic factors).

Follow-up discussion by the entire group:

Discussion opened up in the meeting regarding what the barriers are for doing good work with less funding compared to other fields and what are ways to address these barriers. The difference between the top-down and bottom-up development of the fields has contributed to the struggle to be seen as a legitimate field and get resources to do this work. This also relates to the question regarding effective batterer intervention, with some present at the meeting emphasizing that this question can lead to concerning responses like completely replacing the model of batterer intervention rather than working to improve on existing knowledge.

One of the drawbacks of sex offender treatment being top-down was that it came down uniformly, with the force of a hurricane. It swept up everyone, including anyone who did not conform to heterosexist or traditional notions of partnership between a man and wife. There needs to be recognition in the field of the changing societal understanding of what sexual abuse and domestic violence is, who needs help, and how we can support people.

In the 1970s, as shelters were getting established, people working in them realized that many women were going back to their partners and saw a need for programs that worked with those men. Early programs like the Men's Resource Center here in Portland and the Domestic Abuse Intervention Project in Duluth, Minnesota were founded for short-term anger management to treat the abusive partners. Most of these early agencies were very good about listening to the partners of abusive men and to the advocates and quickly learned that short-term anger management or couples counseling were not appropriate for these cases. They realized that it wasn't about the emotion of anger but about abusive behavior. Beyond that the abusive behavior was often a means of seeking out power through being controlling. This led to the development of specialized curriculums for abusive men, including the Duluth curriculum (and model), Emerge, and others.

Recent efforts to address program effectiveness have taken some concerning turns, with movements in a number of states to replace the whole field of batterer intervention with other models (e.g., corrections programming in Iowa). Iowa launched ACT-V, a DV version of acceptance and commitment therapy, combining cognitive behavioral therapy (CBT) with mindfulness, a cousin to dialectical behavior therapy. CBT has always been a very attractive intervention because it is very concrete and easy to manualize, teach, and research. The first study on ACT-V has come out with some support that it is effective, but some significant flaws (e.g., critique by Gondolf). There seems to be some value in the program, but it does not seem to

be a viable complete replacement. Rather, it should be an enhancement to existing batterer intervention programming. ACT-V has almost no focus on belief systems, no empathy building, and no acknowledgment of impact on victims. It is a classic psychological way of thinking about DV, focusing on changing thoughts but not beliefs. Statewide, DV advocates in Iowa voiced concerns along the way, but their concerns were largely dismissed. After being silenced, they recused themselves from the development process because they were not taken seriously.

An increasing trend is for developers of new programing for abusive partners, often with limited previous experience, stating that "batterer intervention doesn't work" and then proposing an alternative to replace programing. ACT-V is just one example of this approach. While there is certainly room for improvement within the BI field, the process shouldn't be about replacing current programing, which often is built on the wisdom and experience of working with both abusive partners and abused partners. Instead the focus should be on how to enhance and improve upon what is already being done rather than completely replacing it. Ed Gondolf's last book featured interviews with a couple dozen seasoned providers from all over the country, most of whom had been in the field for more than two decades. While those interviewed came from a variety of backgrounds and orientations, there were common themes that emerged. When developing the standards for Oregon, there were disagreements about many things but everyone had common ground in the curriculum because it was a minimum requirement.
There appears to be some convergence within the field on what works and this accumulated wisdom should be drawn upon and considered, rather than discarded without a thought.

There continues to be disagreement within the field on whether the work is therapeutic or not and/or whether people need to have mental health backgrounds to do this work. At a minimum, most curriculums make use of some mental health concepts such as CBT (including Duluth curriculum). Likewise, the push from the forensic field is to include a variety of mental health concepts in terms of best practices in working with offenders. Yet the field has its roots in social justice and feminist work which does not view the issue as necessarily a therapeutic one. This tension may be another thing that has prevented the field from fully developing and left it vulnerable to attacks from forensic and mental health professionals.

Some providers working with offenders may not have the training and expertise they need to do this work well, and many come in and do the work for a year or two and move onto other more lucrative (sustainable) fields. There is also a need to raise awareness of the standards and recognize that this field deserves funding. Some suggest the work should be seen as treatment and not just intervention.

There is also a lack of adequate infrastructure to do this work. To do the work well, programs need to be better funded. In Texas, for example, they subsidize programs and fund programming. They also have a conference with national speakers to disseminate information to people in the field. People are invested in being there, showed up, and learned from researchers and others

talking about the state of the art of working with abusive partners. A major advocacy group was also a co-organizer of the conference, which shows significant support and a sign of the relationship between those working with survivors and those working with abusive partners. Unfortunately, Texas is much more the exception than the rule when it comes to how states support programming for abusive partners.

Funding issues also affect the ability for programs to be compliant with the statewide standards. For example, many new providers (and new staff members of the providers) do not get the required 40 hour training on batterer intervention. Allies in Change is the only agency in the state to regularly offer this training, twice a year. However, typically only a handful of providers send staff to be trained in spite of their being approximately 50 programs around the state. The speculation is that it's simply too expensive and too time consuming when most people doing this work only do it very part time and with it generating relatively little income.

This limited funding also makes it more difficult for programs to be as effective as they otherwise might be. There are a number of appropriate recommendations in the CPC that people are in agreement they should be doing (e.g., supervision, on-going training), but cannot afford to take the time to do. For example, with more money, Allies in Change could have a clinical supervisor for ongoing supervision, training, and disseminating the latest research to peers, but instead has one person serve as the executive director, clinical director, and a frontline clinician.

Another challenge is the quality of partnerships between programs working with abusive partners and programs working with abused partners. Across the country and internationally, the relationship between programs that work with abused and abusive partners varies hugely. Some communities are on the same page, working strongly and well together, while in other communities they are not talking together at all. Within the field of those working with abusive partners, there is typically not the same level of community support for funding domestic violence work with abusive men. Communities seem to have no problem paying for services for people with substance abuse issues or sex offenders, but this is not the case for abusive partners.

In most states, including Oregon, DV crimes are primarily misdemeanors, while many sex offenses are felonies. Typically only felonies receive state funding for supervision and intervention which means that a community has to find money from other revenue streams to fund supervision or management of abusive partners except for those with the most severe charges. On the other hand, people with other criminal charges are rarely screened for or charged with DV crimes, in part because they are legally less severe crimes. This contributes to the higher funding rates for sex offender work compared to DV. Those in substance abuse can also receive more funding from the substance abuse treatment fund, being able to bill insurance, and being more subsidized.

Probation and Parole in Clackamas is trying to help people afford to pay for BIP groups by waiving supervision fees, having an amnesty program, and helping them find employment and housing to alleviate the burden of the fees for BIP groups. This is a way of supporting abusive partners in making changes in coordination with the victims. This is different from supporting the programs themselves though.

One way to support programs would be offering free training, which is what the Tri-County BIP Network strives to do through its monthly meetings. While providers are regularly encouraged to attend and share their knowledge and wisdom while expanding what they know, most months there is typically only light attendance by providers relative to the number of programs located in the Portland metro area. For example, today only two programs are represented out of more than a dozen in the Portland metro area. Likewise, there is often light attendance by providers at local DV council meetings. Again, this is likely due at least in part to providers not being able to afford to pay staff to attend such meetings. Another consequence of this is that providers struggle to network and to advocate for themselves and their colleagues. For example, there is no statewide association for BIPs in Oregon. We can see this parallel with regards to DV councils in counties that offer financial support (by paying for council administrators) versus those who rely on a totally voluntary council. The counties that have paid staff to their DV councils tend to have larger, more active DV councils compared to counties that have all volunteer councils.

Some time was spent discussing how risk and risk assessment play into these funding concerns. The standards were revised several years ago to shorten the required length and tighten up the risk language, but maybe we also need to look at the standards again. We need to work on reaching the larger community and especially low-risk men. We may also need to re-think how "risk" is interpreted, to see that someone may score low on an assessment but in actuality be high risk (e.g., low risk of breaking any other laws while continuing to be emotionally abusive in the home). There also need to be better risk assessment tools for DV. Tools like the LSCMI are helpful for identifying who needs supervision, who is going to break laws, and who we need to do more work on. There is another group though who will never break laws but still need a full course of care and could be potentially lethal, some of whom do and do not enter the system. It may seem like they only need a short course of care, but they have risk factors that will not show up on those screening tools.

Maybe the BIP reviews and CPC process can become more collaborative to legitimize programs and make them more able to attract funding. This process could be more of a conversation or dialogue in both directions, with providers giving feedback on where it is challenging or hard to meet the standards as well as learning ways in which they can better meet the standards. Collaboration could also facilitate obtaining clients' criminal records and having more collateral information going into the interaction with clients, because time and money are wasted while providers wait for the full picture. Greater collaboration across programs could also support the

need for same-sex groups by coordinating referrals so that a designated provider could facilitate groups for sub-populations that may not be large enough for every program to run a group for them (e.g., juveniles).