Tri-County Batterer Intervention Provider Network
Tuesday, April 14, 2009

Attendees: Chris Huffine (Allies in Change Counseling Center), Jennifer Warren (Men's Resource Center/Women's Counseling Center), Curtis St. Denis (Multnomah County Corrections/Allies in Change/Portland State University), Andrea Poole (Manley Interventions), Paula Manley (Manley Interventions), Jacquie Pancoast (ChangePoint), Dean Camarda (Men's Resource Center/Allies in Change), Roberto Olivero (Men's Resource Center), Sara Windshemier (Choices), Paul Lee (Men's Resource Center), Tammie Jones (DV Case Manager Oregon Dept. of Justice), Joan Scott (Allies in Change), Dianna Kingdon (Men's Resource Center)

Minutes by: Jacquie Pancoast, edited by Chris Huffine

TOPIC OF DISCUSSION: **LEVELS OF TREATMENT FOR DOMESTIC VIOLENCE PERPETRATORS**

The discussion regarding levels of treatment for Domestic Violence Perpetrators has been brought to the Network for several reasons. Senate Bill 267 requires that State monies be spent on Evidenced Based Practices (EBP)--what does the research say about levels of treatment for DV perpetrators? Several counties in Oregon have already implemented the use of levels of treatment for perpetrators required to complete a DV program, typically using a risk assessment tool such as the ODARA to determine length of treatment. What is the empirical support for such an approach? As it stands now, some counties are resisting requiring the state standard of 48 weekly sessions plus 3 monthly follow-ups because it costs too much. Which individuals might be most appropriate for a shorter length of programming?

Comments and concerns presented by those in attendance were:

It appears that currently individuals are being referred to specific levels of treatment based on the use of risk assessments which address physical abuse – not emotional/psychological abuse and therefore are not appropriate for determining level of placement in treatment. Providers have to be careful of our own personal biases or subjectivity. Research indicates that risk assessment tools are preferred over a provider's personal opinion or judgment. However, they were not designed to be used as a placement tool for perpetrators into different lengths of BIP programming.

There is a concern that DV intervention lacks research to support both current levels of treatment implemented by SB 81 and graduated levels of treatment. There is a challenge to meet this need for empirical data – what works and what doesn't. There are limited resources for this type of research and therefore the current focus is on addressing those at the highest risk.

There seemed to be more agreement that EBP supports the separation of individuals around

levels of risk vs. length they are in a program. In other words, while it may make sense to identify and target the highest risk clients (consistent with LaTessa's research and his program assessment tool the CPC), that does not mean that the key factor should be length of programming. Instead that may lead to placement in specialized groups such as those focusing on clients with higher criminality or co-existing mental health issues, which are currently being offered by a few programs in the state.

It was stated that there is a need for extensive training to identify high risk individuals, criminally oriented men – for both BIP staff and referral sources. (How to assess them, separate them from regular group settings.) Reading a client's criminal history, not just current arrest information, needs to be part of the assessment, along with case staffings, probation input, and intake assessment information. It was stated that this is an area which seems to benefit from repeated training. Probation cannot provide a copy of a client's LEDS, but can give a verbal account of LEDS.

When it comes to referring an individual from a regular group to a more criminally oriented group, providers have not experienced a high level of resistance from clients.

Providers who have been in the DV field for a period of time, have had experience with 12 week programs, and have watched that gradually increase to the current 14 months. Based on this personal experience, they support the longer engagement in programs. Many providers have had feedback from client's themselves as well as their partners supporting the longer programs.

A concern was raised that if a referral source refers a client for 12 weeks, with recommendation from providers for longer engagement, this may negatively impact providers role with client – to client seeing provider as being aligned with the criminal/legal system rather than the client.

Comment was made that if DV providers have an overall sense that a 12 week program would be dangerous for the majority of offenders, then it is important that this be presented to those who are suggesting the implementation of levels of treatment.

It was noted that currently there is no compelling research indicating that longer treatment is better. Gondolf's research actually found no difference in effectiveness of programs of differing length. However, this is complicated by the extent of the coordinated community response and court involvement, which was greatest with the program of shortest length in his study.

It was stated that Multnomah County Judges will be meeting on May 29th to discuss the issue of lower levels of treatment. It was recommended that providers, advocates, and others who are concerned about this issue, attend the meeting. More information will be provided regarding the time, date and location when available. EDITOR'S NOTE: AS IT TURNS OUT, THIS WAS A JUDGES ONLY MEETING.

As providers, we should be open to exploring what is actually best practice – supporting research

regarding this issue. In the meantime, there appeared to be a consensus to support the longer treatment requirement until we have support for something different.

It is important that providers not appear rigid regarding treatment options, but do support further research to support any modifications for future consideration.

More information from victims' experiences might impact the level of treatment recommendations.

Some questions raised:
Human behavior covers a broad spectrum – how do we assess for a history or pattern of abuse? How do we put a number on weeks of treatment without appropriate research. How do we measure the efficacy of programs? Why are some men not referred to a DVIP?

What would be rationale for offering a lower number of group sessions, since the evidence is not there to support or not support differing lengths of treatment. Who, exactly "only" needs a shorter program? What is the rationale, aside from cost, for placing certain individuals in a shorter program?

Currently it seems that District Attorney's will ask for a lower number of group sessions, yet some providers present reported no evident positive outcomes/change with individuals who have completed 12 weeks in a program.