Tri County Batterer Intervention Provider Network Meeting Minutes
May 8th, 2012

Attendance: Jen Warren (Seeds of Change Counseling), Guruseva Mason, Maggie Kerlin (Allies in Change), Cassandra Suess (Allies in Change), Samantha Naliboff (VOA Homefree), Jennifer Hopkinson (Clackamas Women's Shelter), Emmy Ritter (Raphael House of Portland), Regina Rosann (ARMS), Tim Logan (Sovalti), Joan Scott (Sovalti/ Allies in Change), Jacquie Pancoast (ChangePoint), Wendy Viola (Portland State University), Katherine Stansbury (ChangePoint/Turning Points)

Minutes by Wendy Viola, edited by Chris Huffine

Topic: Risk/Need/Responsivity & Sexual Offense Specific Risk Assessment

Presenter: Katherine Gotch, MA (Katie.c.gotch@multco.us, kcgotch@gmail.com)

"Dynamic risk factors" are identified areas of need, which become targets of change.

We get a lot of the same questions in the BI and sexual offense (SO) fields, regarding rates of recidivism, supervision, and rehabilitative and treatment needs.

Some in the SO field talk about a fourth generation of risk assessment tools, in addition to the first three generations. In Katie's presentation, the third and fourth generation risk assessment tools are discussed together.

The ODARA and the Static 99 are examples of actuarial assessment, which are research-based, and address offenders' previous histories. They can't measure change over time, and they have only moderate levels of prediction (.65 - .7 area under the curve).

Third/Fourth generation measures look at offenders' dynamic factors, as opposed to only static factors. There's a trend to focus treatment on those factors that are most related to recidivism for individuals—instead of working through the same 6 treatment modules for every offender, offenders will participate in some modules but not others, depending on the support and strengths offenders already have or are lacking.

In the SO world, recidivism is measured by violation behaviors, general recidivism, violent recidivism, and sexual recidivism. Good recidivism research considers re-arrest and re-conviction rates. Because DV hasn't been as politically charged as sexual offense, it's unlikely that people will invest the same amount of money into developing tools that has been the case in SO. Furthermore, there's a lot of resistance to research in the DV field because it's more of a grassroots effort and a lot of the tenets of BI are based on perceptions and beliefs about what we think makes a difference for batterers (i.e. there

isn't a lot of research that accountability actually reduces recidivism). Research on sex offender treatment is about 20 years ahead of research on IPV perpetrators.

In general, denial does not predict recidivism. Denial may be predictive for some offender types, but not all. Denial may not be symptomatic of a lack of empathy, but a product of fear of losing one's entire network if they admit to having committed a sexual offense.

Canada funds a lot of large-scale research studies to validate measures and assessments. Every time someone is arrested, they must undergo an assessment, so Canada has put a lot of work into developing accurate assessment tools.

Research is being consistently conducted, and measures are adjusted as new findings are established. Standards are set through such a lengthy political process that it seems to never be up to speed with research. However, research on recidivism in particular tends to be so longitudinally oriented that it doesn't move *that* much faster than things like standards. But there are other roadblocks to incorporating current research into practice, like the systemization and computerization of new tools. All of the dynamic risk assessment tools are newer instruments. Oftentimes, the current research will just reinforce or tweak what you're currently doing. There's a lot of variation between jurisdictions in the adoption of best practices.

There aren't very many needs assessment tools for IPV perpetrators—maybe the LS/CMI. Needs assessments are assessments of dynamic risk factors. Treatment providers in the BI world typically don't get criminal histories, which are necessary for conducting good risk assessments. Sometimes providers get their clients' LS/CMI though they're often unaware of their criminal histories. The group believes that PO's would be resistant to keeping BI providers' informed of their clients' arrests, as they've never been asked to do so. Additionally, because IPV is such an under-reported crime, such a small portion of offenders' histories would actually appear in criminal histories, making that small portion of information especially valuable. Most of the information that providers receive is from the men themselves or from the other men in their groups.

Conducting groups for different genders, language and cultures is a facet of responsivity. Static risk factors are historical and unchanging over the course of an individuals' life. Acute risk factors are temporary, passing conditions or behavior.

There's a lot of cross-training that should occur—perpetrators don't fit neatly into boxes of being either sexual offenders or batterers. There's a lot more cross-classification than corrections likes to believe there is, so the clinical community is better prepared to deal with these cross-classifications than corrections. There is a county staffer who specializes in "cross-over" cases—men who have perpetrated both sexual assault and intimate partner violence. Within Multnomah County, there's a decent amount of fluidity between

categories of needs and risks—men can move between SO and BI treatments and supervision. Being able to do so requires looking at dynamic risk factors as opposed to just criminal histories.

"Over-supervision" and "over-treatment" can and do lead to increased recidivism and higher risk.

Polygraphs and UI's are used much more often in SO supervision than in IPV. We rely much more on self-disclosures from men who have every reason not to admit to having perpetrated abuse. Polygraphs are often misused—it's not as much about whether or not men pass the polygraph test as it is about what they disclose immediately before and after the test. Placing too much credence in polygraphs is a big issue. It's no longer considered appropriate to send offenders back to treatment or to terminate their treatment on the basis of their polygraph.

Identifying overrides involves looking at the circumstances under which overrides are granted on the basis of judgment calls about classifying individuals' risk (i.e. a sex offender, preferential child molester, who was dying of cancer and physically incapable of perpetrating a sexual assault).

It's essential that providers meet their clients where they're at, which requires being trained in multiple treatment modalities or theoretical backgrounds, and be prepared to refer out to other providers who might be better able to meet a client where they are. This can be fostered by creating more of an identity as a treatment community of providers with different strengths and weaknesses who can fill in gaps for each other. Within the SO community in Oregon and in Portland more specifically, there's a rise in collaboration and referrals among individuals who specialize with specific populations—providers have different skill sets and it's beneficial to everyone to maximize these skill sets and look for good fits between providers' skills and offenders' needs. Local and regional systems have very different approaches to collaboration between providers.

How do we measure success for clients? BI providers rely on completion of assignments, letters of accountability, aftercare plans—but these aren't necessarily signs of "success" as participants could do all of these things and continue to perpetrate abuse. Providers don't always hear when partners call, when men are arrested or there are new restraining orders, etc. In the SO world, being discharged from a program isn't a great measure of success—it can be a success to get a participant tuned into the program for a few months at a time and that can be a success. "Maximum benefit" does not refer to having completed a successful discharge, but it indicates that an offender has taken away everything that they can from the program. For example, people who are in staunch denial of their offense behavior may have done well in other aspects of the program, but they aren't going to come around to change their denial, in which case they'll be discharged from the program, but monitoring will continue. Some BI providers will use

this as an excuse to keep a participant in the group, even if they acknowledge that they won't change, just to be another eye checking up on the offender.

SO treatment is not as much evidence based practice as much as research-guided practice. A lot of people in corrections don't distinguish between the two.