Tri-County Batterer Intervention Provider Network Meeting Minutes January 14th, 2014

Attendance: Chris Huffine (Allies in Change), Jeff Hartnett (ChangePoint), Jacquie Pancoast (Eastside Concern), Katherine Stansbury (Eastside Concern), Mark Amoroso (MEPs Counseling), Dominic Del Bosque (Washington County Probation and Parole), Amanda Briley (Bridges to Safety), Krystal Duff (Bridges 2 Safety), Jaime Chavez (Cedar Counseling Center), Sandi Rorick (Multnomah County Probation and Parole), Regina Rosann (Abuse Recovery Ministry and Services), Wendy Viola (Portland State University), Suzanne Guy (Multnomah County Domestic Violence Coordinator's Office), Diana Groener (Allies in Change), Olga Parker (Modus Vivendi), Phil Broyles (Teras Intervention and Counseling)

Minutes by Wendy Viola, edited by Chris Huffine

Topic: Why Doesn't Batterer Intervention Get More Respect?

Chris brought hand-outs of a PowerPoint presentation, a copy of which is attached to the minutes.

Through interacting with other participants at the Institute on Violence Abuse and Trauma Conference (IVAT) and other conferences and listservs of BIP providers from around the country and globe, Chris has believes that, as a community, batterer intervention is under-researched, under-trained, under-funded, and doesn't get much respect. It seems that other fields look down their noses at BI. A lot of methods that BIPs use *are* evidence based, but once they're used by BIPs, they lose their credibility.

It's hard to get people who do batterer intervention work to attend training. Allies in Change is the only agency in the state that offers a 40-hour training, but it's usually only attended by 5 – 6 participants from outside agencies each time it's held. There is no national DV organization, and Oregon hasn't had a statewide group in years. There hasn't been a national BI conference in 4 – 5 years, and the most recent conference that was held was very lightly attended. The IVAT conference, held every September in San Diego, is currently the only on-going conference that has a fairly large turn-out of batterer intervention providers from around the country.

There is no certification in Oregon for BI providers, while interventionists in other fields do require certifications. The existing state standards for BIPs are not enforced. In the alcohol/drug abuse and sex offender fields, there are established outcomes that demonstrate that treatment is working (i.e. using polygraphs and UA's), but we don't have comparable ways to prove that BI work is having an effect. Culturally, we're much more motivated to provide treatment to sex offenders than DV offenders. Sex offenders display a much wider range of offending behaviors than DV offenders yet the sex offender field is much more advanced.

There is some research that shows that some offenders do change while in treatment. However, by conducting DV intervention work, we're acknowledging a deep and shameful social problem and it will take a long time to see real change at the societal level. At this point, *many* people

have filtered through BIPs and many more have come in contact with these agencies through other community members; all of these (hopefully) changed individuals may contribute to change at the societal or community-wide level.

The history if the DV movement is a social justice and grassroots movement, as opposed to a forensic movement (e.g., the sex offender field) or a movement grown by people struggling with addiction themselves (e.g., substance abuse). As a result, it has very little tie-in to scientific or psychological fields, which makes a difference in the way that the field is viewed. Historically other fields have done a poor job of understanding and addressing DV (e.g., psychology, substance abuse). There's also a stigma, and a sense of guilt-by-association, towards people who work with perpetrators, including by some of the people who work within the larger DV field.

Our culture doesn't take DV very seriously, as reflected by the fact that most DV crimes are misdemeanors. As a result, there isn't very much money for perpetrators' treatment or supervision. There's much more money in the criminal justice field around addiction and sex offender treatment. There just isn't the same amount of money for BI work, so many providers do BI work as only a small portion of what they do. Because of this they don't spend the same time and resources seeking out training that they would if the DV work was more of a primary focus.

Another challenge includes the tension and struggles within the batterer intervention field itself. Within the BI community, there's still a conflict as to whether the work is treatment or intervention, which isn't the case within the sex offender field. The community of people who work with sex offenders is very clear that their work is treatment, and as such, there are much clearer levels and requirements around certification.

Relative to the general population BI tends to see a disproportionate number of working class men and men of color. This also may be the case relative to the caseloads seen within other forensic fields. We're seeing primarily impoverished people, so we have to use sliding scales in order to work with them which means that there is less money to pay for staff or training. Because more of our participants are from working class backgrounds, they can't advocate as well for providers who are better trained, nicer facilities, etc. Additionally, providers' ability to seek out training and resources are limited by the amount that they can charge clients who don't have very large incomes. Inconsistencies among providers with the same level of training is another problem for establishing credibility in the field. The silver lining is that BI draws a very dedicated group of people, who certainly don't do it for the money. There are only a few providers who do manage to make a profit, mostly by hiring under trained staff and not paying them very well and running very large groups.

If someone doesn't have the money to pay for services, do we leave them without any services, or do we subsidize their services? This isn't a question for the sex offender treatment and addiction fields, where subsidized services are a given. One reason that these services can be taken for granted is that, socially, we've started to recognize their impact on the community. As

a result there is more widespread support to pay to help stop those behaviors. This same stance is not yet present for DV perpetration which is still often viewed as happening elsewhere (i.e., "it's not happening in my neighborhood/community) and as generally less of a community concern since the victims are, by definition, within the perpetrator's own family. Taking domestic violence more seriously will be necessary to generate further funding and support for the programs that work with abusers.

Another way that the DV field differs from other forensic fields is that victim blaming (e.g., "why didn't she leave?", "it takes two to tango") appears to be more common and acceptable whereas sex offenders and addicts are more likely to be seen as the sole cause of their bad behavior.

In this context, the idea of batterer intervention being the "ghetto" of forensic work is understood in the following way: the struggles of those therein are neglected and overlooked, the infrastructure is compromised, and the residents themselves are blamed for their problems. As people accomplish more and more, they leave the ghetto, the upwardly mobile leave the ghetto behind and no longer advocate for the ghetto. Ghetto populations don't have much political power or voice. The ghetto and those within it have value and worth, but that is often not seen, acknowledged, or is minimized. It is falsely characterized as worthless and having little value. There's a lot of skepticism and dismissiveness towards BI providers, many people can't afford to continue doing the work, and BI providers are paid significantly less than people with comparable degrees in other fields. There's very little reliable research, few reliable research tools, and very little data regarding BIPs. As a group, we're unaware of any particularly good assessment tools for either male or female perpetrators.

The idea of subsidizing perpetrators' BIP participation has been controversial. Currently, the consensus seems to be that participants who aren't serious about treatment aren't going to be serious about treatment, regardless of whether or not they're paying for it themselves. This becomes a class issue: the men who are most financially burdened by their program participation are the ones who are poorest, which doesn't sit right. Using a flat rate disproportionately affects working class men. DHS has inconsistently subsidized BIP participation. One provider a number of years ago explicitly discouraged Child Welfare from approving subsidies for abusive men, stating that paying for their services did not hold them accountable and was a form of collusion. This stance clearly did not sit right with some Child Welfare workers and in the past couple of years there has been an increase in subsidizing abuse intervention as that old way of thinking has been challenged and questioned. One strong point is that many abusive men will be back in the home and with their victims. To financially punish them means punishing their victims as well. A refusal to subsidize is also classist as it will most negatively affect the poorest of the men.

Sometimes insurance companies pay for treatment. Whether providers should bill insurance companies for services is another controversial area. The DSM doesn't do a good job of describing diagnoses that are pertinent to DV. Some providers identify diagnoses that are closest to DV perpetration so that they can bill insurance. Some providers object to this process because

they believe that domestic violence is not a mental health issue, but a choice and a criminal behavior. It was pointed out that sex offenders can be assigned diagnoses and addiction can be easily linked to diagnoses, so treatment in these fields can be billed to insurance companies. Another concern voiced is that the use of insurance relieves the perpetrator of any financial responsibility/accountability. However, most insurance plans have a copay, so it is unusual for a man with insurance not to have to pay something. The only group of BIP participants that gets a full ride are sometimes those on subsidies through child welfare or probation.

There is some degree of consensus that all program participants should pay something, but we should be mindful of individuals' economic situations. For some participants, having a full ride makes no difference in their motivation. For others, putting a small barrier in the way of their participation will totally dissuade them from engaging with the program, while others still won't participate very willingly even if you remove all of the barriers for doing so. Providers can include this in participants' progress notes. It can be helpful to come up with agency policies that you can refer back to later, regarding what DHS will pay or not.

To some providers, it feels as though there is more clinical humility among sex offender treatment providers, in addition to more ongoing research and theory development. In the DV world, it's easier to trick yourself into thinking that you know everything, and ceasing to pursue training and education. We need to build an infrastructure for exchanging information across states and countries. Being required to get CEUs can be very helpful. There's still dogma around the way that things are done (i.e., this is THE way to do this work and it shall not be questioned) in the DV world, in part because our lack of roots in science and empiricism has contributed to contempt for research.

Collaboration between providers, victims services, the courts, DHS, etc. is still really fractured. We are part of the victims' safety movement, but that often gets overlooked.
Tying our wagon to sexual violence might help our work gain support. The fact there's no peer movement, as there has been around addiction, may also keep BI work from gaining more public support. As a society, our orientation towards addiction has changed dramatically, but there's still socially sanctioned shaming around DV perpetration. It's easier to have a self-help group around sobriety than around accountability, because it can be difficult to keep groups of perpetrators from falling into collusion.

Another challenge is that DV is still seen to some extent as a perpetrator-less crime. We are much quicker to talk about victims and address that issue than perpetrators. For example, we still aren't thinking about perpetrators in a lot of one-stop shops for DV, besides considering arrest and incarceration as possible solutions.

There's much more understanding about addiction than DV among the general public, so there aren't as many people on the ground who know how to identify it. Most probation officers don't even think that people on their caseloads could be DV perpetrators. We're not doing a good job providing support and education to collaterals the same way that there's ALANON, etc. for

collaterals of people with addiction, in part because we don't want to put collaterals in the position of being responsible for perpetrators' behavior.

Another challenge is that DV can occur without committing a crime. All sex offending behaviors are crimes, but this is not the case for DV. This is similar to addiction—it's not illegal to drink or to gamble, but these behaviors are destructive for a group of people. Within the addiction field, where legal repercussions aren't always a deterrent, there is a lot of research around motivation and recognizing the impact of your behavior on yourself and others.

BI work is challenging and requires skills that improve with time and experience. We have to reduce turnover so that BI providers are more seasoned. The idea of having compassion for perpetrators (in wanting to help them change) is still provocative. When you have a compassionate relationship with your clients, you're much more likely to help them change. You also have to model the respect, empathy, and regard that you want participants to show to others. The stories of DV that show up in the media are the ones that grab people's attention. A lot of these stories portray perpetrators as sociopaths, which isn't true of most of the men that we work with. The media paints perpetrators with such a broad brush that isn't an accurate representation of real life, and it's hard to convey this to the public.

If we asked all of the providers in the room to write down our goals for our BI work, we'd probably get different answers. However, if we observed the groups that everyone facilitates, we'd see that we do very similar things. We get so busy arguing about the terms that we use to describe our work that we come across as more fractured and less stable than we are.

<u>What can we do about this?</u>
Providers need to be willing to come to meetings and training, and we know that not all of our colleagues do that. We need to be willing to speak up about batterer intervention and about perpetrators so that they're included in the discussion about DV. We also need to be consuming the research. Eric Mankowski continues to serve as a great resource to this group in his ability and willingness to share his knowledge of current research. Our collaboration with academics can help generate more studies and research materials to inform our work. One challenge of doing research in the field is the difficulty of measuring program success and determining whether and how perpetrators have continued to offend or not.

We tend to focus more on DV behaviors, as opposed to belief systems, which is what separates perpetrators from the rest of the population who make mistakes. We're not doing much work with younger men who are rapidly adopting chauvinistic belief systems. It could be very influential to bring prevention work into schools, which are currently lacking classes on healthy relationships. If there was more of a community push to get into the schools, we might have more success. A potential entry point may be parent-teacher organizations, which are a bit more open than school administrations. We haven't done a lot of work with parents about social media and technology and access to pornography. Parent coordinators put together workshops about sex offenders, maybe it would be possible to do something similar regarding healthy relationships.

One problem is the way that healthy relationships are conceptualized: we're still talking about them in terms of physical violence, when we now understand that the core defining quality of DV is one's belief system. We haven't even agreed on the language with which to educate kids about healthy relationships.

Not a whole lot of movies encourage sexual abuse or addiction, but there are thousand and thousands of hours of media portrayals of how to be a man. Even if men have more egalitarian views of women, it would be very difficult to be open about having this belief system as a young man. Clackamas Women's Services is working on a youth prevention program. Local faith-based organizations have a lot of internal programs. Most of them have support groups for men struggling with addictions, including pornography addiction.

We agree that there is tons more to be done to help improve the quality of work being done with abusive men as well as being shown the respect we deserve for doing this vital and important work.