Tri-County Batterer Intervention Provider Network Meeting Minutes May 13th, 2014

Attendance: Chris Huffine (Allies in Change), Sandi Rorick (Multnomah County Dept. of Justice), Curtis St. Denis (Allies in Change/Cedar Counseling), Linda Castaneda (Manley Interventions), Regina Rosann (ARMS), Wendy Viola (Portland State University), Suzanne Guy (Multnomah County Domestic Violence Office), Katherine Stansbury (Eastside Concern), Matt Johnston (Domestic Violence Safe Dialogue), Chuck Murdock (Bridges 2 Safety), Phil Broyles (Teras), Tammie Jones (Domestic Violence DV Court)

Minutes by Wendy Viola, edited by Chris Huffine

Topic: Working with high risk and/or psychopathic abusers

Editor's note: Curtis St. Denis made substantial contributions to this topic, which was more of a presentation by him than a group discussion, although others did participate.

It's important to acknowledge that not all abusers are the same. As a community, we're becoming more thoughtful about the ways that they differ, specifically with regard to their risk of recidivating. The intention of the current meeting is to focus on the perpetrators who have the highest risk of reoffending, and the subgroup of those high-risk offenders who demonstrate psychopathy.

What does it mean to be high risk? High-risk offenders may use more extreme forms of violence than lower-risk offenders, and high risk offenders become more dangerous when they are subject to restraining orders (as opposed to lower-risk offenders, who are most likely to respond well to restraining orders). High-risk offenders may also be less likely to comply with program requirements. There are several different types of risk that we may be referring to including risk of using lethal violence, using general violence, or criminal recidivism more broadly. While there is significant overlap between these risk groups, they are not exactly the same. The indicators of risk for lethal violence differ from the indicators of risk for other forms of violence. For example, those who commit lethal violence often don't have criminal histories, which is an indicator of risk for other types of behavior. Risk can also refer to the likelihood of physically assaulting a victim again, violating probation conditions, or breaking laws in general.

The DV field is focused on lethal violence or physical assault, but the reality is that many BIP participants are at a very low risk for these behaviors. Many providers are also concerned with reducing verbal and emotional abuse, which underlies physical violence, but which is not illegal. Risk assessment tools do not capture the risk of using emotional or psychological abuse. There are other risk factors that these tools don't assess which are important for providers to consider. Overall, however, we are most concerned with the participants who are most likely to commit future violent crimes.

Risk factors may be static, dynamic, or acute; moving individuals from high-risk to low-risk necessitates focusing on the dynamic or acute risk factors, which we may change. For more information on risk assessment, see the minutes from the January 2013 meeting. As a field, it would be effective to embrace the risk-needs-responsivity model to a greater extent than we have; the model focuses closely on dynamic factors.

Using a tool to assess risk is much more effective than using structured professional judgment, and reduces the likelihood of egregious under- or over-scoring of participants. However, it can be challenging for providers to gather all of the necessary information to complete formal risk assessment tools, and providers have to rely on PO's and advocates to provide necessary information. Greater communication between treatment providers and PO's may improve the completion of detailed risk assessments, by increasing the flow of information needed to complete risk assessment tools. Sometimes even PO's don't know that the information that they have about participants would be helpful for providers to have. For example, the ODARA asks for victims' perspectives, which providers don't have, but Multnomah County is required to make contact with the victim, so they would have this information. Most tools also have procedures for what to do in the case of missing some information. Regardless, we could still rely more heavily on the risk assessment tools that are available. The field doesn't have much language around risk assessment, and is therefore often hesitant to discuss it, as opposed to sex offender field, where risk assessment is engrained in the culture and enables the placement of offenders in appropriate treatment programs. Many providers don't receive sufficient information to identify participants as high-risk right away, but sometimes, information about participants is so egregious that it cannot be ignored.

There are other limitations even to established risk assessment tools. The ODARA assesses risk with regard to a single victim, as opposed to in general, or in later relationships. Similarly, most research only considers risk with regard to participants' current partner. There isn't much research that follows perpetrators for over 3 years, either. However, if participants are going to recidivate, they are much more likely to do so within the first year after beginning a program.

There is a danger that we don't know when we're looking at a high risk offender in the eye. Most people outside of the field would be stunned to understand that we work in the violence intervention, yet we don't know who is most dangerous. There is some debate within our group about whether we should use imperfect risk assessment tools, or whether we should avoid assessing risk if we cannot be confident that we're doing it accurately. False positives create an extra burden for PO's, however, as providers, we'd prefer to err on the side of being overly cautious.

There's a significant amount of overlap among the risk assessment tools, and there's an association between general criminal recidivism and DV recidivism. The men who are most likely to commit violent assaults are also most likely to commit probation violations, and to commit new crimes. Community corrections uses a combination of the ODARA and the LSCMI

to determine risk, and thinks about risk in terms of the frequency of breaking the law and violating the conditions of parole or probation. Multnomah County is beginning to screen people for risk of pre-adjudication. This entails a pre-sentence investigation into whether individuals would be good candidates for "dispositional departures" before judges make any sentencing decisions or pleas are worked through. More and more often, judges are thinking about tiers of treatment, acknowledging that one size doesn't fit all.

Some risk factors that are particularly indicative of high risk are the following: (note that these are not set in stone, and that the clustering of risk factors is more important than the presence or absence of any one of these factors independently):
-extensive criminal histories
-age (being young is a risk factor for recidivating)
-accessibility of the victim
-stalking, rumination, a heavy preoccupation with the victim (this can be difficult to define clearly)
-how much the client "has to lose;" how much going to jail is going to hurt him (more important than having a job is having a job that you enjoy and that you value more). This is related to suicidality, which is an important risk factor but which is rarely included in risk assessment tools.
-Victims' assessment of their own safety or danger, which often needs to be provided by the referral source.
-Participants' ability to get to the program and their barriers to success in the program.
-There's a very modest relationship between reliable attendance and risk level, to some extent, but a lot of the behaviors that we see in groups are not particularly good predictors of risk. For example, continued victim blaming is *not* a risk factor, neither is denial, or a preoccupation with firearms.
-Substance usage, which is often closely related to mental health. It can be difficult to disentangle the two, pointing to the necessity of looking for an accumulation of acute and dynamic risk factors.
-Strangulation
-victims' status as pregnant
-the presence of kids that aren't his own is more related to lethality than to recidivism in general, but is also very important to consider.

Risk assessment is an ongoing process. It's something that shouldn't be done just at intake, but throughout involvement in a program. Clearly what needs to be monitored most closely are the dynamic risk factors which could change as well as any that are more acutely elevated.

<u>Psychopathy</u>
Psychopaths are a subset of particularly high-risk offenders. It is widely believed that they do not have a conscience; they lack the ability to feel deep empathy, and they can often lie very well. There's a subgroup of psychopaths who most people can sense, while there's another subgroup who go largely undetected. Some psychopaths will lie about the smaller things that they've done,

but be quite honest and graphic about the larger, more substantial acts of violence that they've committed. They tend to be exploitive and parasitic.

It's important to be cautious about labeling people as psychopaths; as an alternative, we can talk about having a number of psychopathic traits or psychopathic instances in which we turn off our sympathy for someone.

The tool that's considered the gold standard for identifying psychopathy is the Psychopathy Checklist-Revised (PCL-R), which contains 20 items, requiring extensive information from collateral information. We're looking for a constellation of traits which are the core features of psychopathy, including having very few attachments, shallow attachments, shallow affect, and a lack of empathy. People with these traits often don't have very much insight in their own behavior.

Diagnosing people as psychopaths without using the PCL-R is dangerous. The masculine norm is to display a shallow affect, callousness, a lack emotionality, and a tough guise (all of which are common qualities of psychopathy). Psychopaths fake the opposite (they fake having emotions and empathy). It's important to avoid being fooled and mix up these two sets of characteristics. If you diagnose someone as a psychopath, people take things away from them, decreasing the amount that they have to lose and thereby increasing their risk further still. However, if providers say that someone is *not* psychopathic, others become disarmed, but the combination of shallow affect and a lack of empathy is a huge risk factor, regardless of a diagnosis of psychopathy.

It's possible to identify men with possible psychopathic traits during empathy building exercises. Most of the time when programs address empathy, the group gets very morose, and anyone who's still pretty cool and relaxed during that conversation probably has psychopathic traits and should be screened more thoroughly using the PCL-R.

Psychopaths are much more likely to use drugs, especially in combination, and they have a much higher crime rate in general. These men do the most damage and engage in the most impulsive and extreme violence, so shelters see many of their families.

It is inappropriate for men with psychopathic traits to participate in groups of low- to medium-risk participants. Their disclosures can traumatize other group members. For example, one psychopathic participant reported casually and explicitly that he'd badly beaten up his brother that day, and was disturbingly explicit in his description. Psychopaths tend to encourage more of an antisocial stance in general, soliciting collusion from other group members. Conversely, they may say all the right things in a group and disarm everyone into thinking that they're doing treatment right. These participants who seem "too good to be true" actually have the highest risk because we know so little about what they're actually thinking. It can also be heartbreaking for other men in the group when they figure out that these "too good to be true" participants are really faking their progress. They can also have sudden acts of psychological abuse in groups.

Other participants in non-psychopathic groups really don't miss the psychopaths when they leave the group; most often, there's relief from the other participants.

High risk participants who are non-psychopathic shouldn't be placed in groups for psychopathic men, because it will make them more dangerous. As a middle ground, it might be optimal to conduct separate groups for non-psychopathic men who still have extensive criminal histories. Currently, these participants end up in the psychopathic groups.

Clinical lore is that people high on these traits can't be helped. They can't be helped using standard treatment options, but different treatment modes can be effective. Allies in Change runs groups specifically for psychopathic men. Is there any support that the specialized group is working on? There isn't much research to draw from. For several decades, there has been a belief that psychopaths may get worse with treatment, but the treatment that was used to come to this conclusion was very out there, and is not a form of treatment that's widely used any more. Psychopaths may have better outcomes with cognitive behavioral treatment.
Regardless, anyone running groups for men with psychopathic traits need to be experts.

The "criminally oriented" group at Allies in Change are much more behaviorally oriented. These groups try to leverage things that bring participants pleasure (money and things), so they have something to lose and which they'll be motivated to preserve (non-psychopathic participants can be motivated to maintain relationships; that is not the case with psychopathic participants). As a result, groups for psychopathic men talk about costs of DV in more financial and tangible terms. They also address how participants may develop a responsible lifestyle and cope with people who are much more emotional than they are, and how they may avoid shooting themselves in the foot. There's often a temptation to confront these guys more strongly, but they enjoy being confronted and do not respond well to it. As a result, the style of facilitation and the demeanor of the facilitator must be qualitatively different.

When providers believe that certain participants are particularly high risk, do they treat them differently? Providers do (or should) prioritize making contact with high risk offenders' referral sources and PO's, and generally, play favorites with high risk offenders (calling on them most often in group, making sure that they always get time when they need it, responding to them most quickly, engaging them after group). Most agencies have participants of all risk levels in the same groups and must negotiate this heterogeneity. Allies in Change is the only program that makes some effort to sort participants based on their risk level. Other programs usually turn away participants who they identify as inappropriate for treatment, for example, as a result of drug use, which, circuitously, could make him higher risk. Some programs give high-risk participants a chance, and for some, it ends up working out quite well. In some cases, though, high-risk offenders are very disruptive in groups, in which case, it's best to remove them from the group as soon as possible. The way that the system is set up now, there aren't many pronounced alternatives for high-risk offenders.

There are some providers who treat everyone as though they're low risk and some who treat everyone as though they're high risk. These programs tend to reach the subsets of clients who they are catered to very well, but don't get through to the others. What works with lower risk clients that wouldn't work for these high-risk participants? A lot of the lower risk clients are "good men who behave badly," and providers try to help them see this and point out the discrepancies between who they want to be and who they are. High risk participants tend to have longer criminal histories and respond much more to strategies that emphasize their own well-being (how to stay out of jail, how to make their PO's happy); providers may emphasize the court system and use it as leverage. There is also certain material that providers should bring up with high risk participants, which isn't relevant for low to medium risk participants (e.g., obsessiveness, depression, more pronounced violence, schemas from childhood around witnessing violence).

Multnomah County is aware of the different styles used by each treatment provider and tries to do treatment matching (hence the "responsivity" aspect of the risk-needs-responsivity model). There are restrictions in terms of potential participants' physical access to particular programs and their ability to pay, but in general, there are attempts to match participants to the provider who would be most appropriate for them. This is easiest in Multnomah County, where we have a larger population and many programs, but many counties have much more limited options.

Intake is very important for determining where to place participants. It is highly recommended that programs use a risk assessment tool at intake. Programs should strive to funnel participants with mental health issues into one group, and those with other histories into other groups, and to sort participants by their risks and needs simultaneously. If providers can't find appropriate groups for high-risk participants, you can refer them to individual counseling with therapists who understand the issues involved in working with high-risk DV offenders (Cascadia has a number of appropriate therapists, and Providence tends to do thorough needs assessments). Providers may also stray off topic in groups to address risk factors that are more peripherally related to DV (i.e. drug abuse, which is a risk factor, but not necessarily part of the curriculum).

Another idea is to invite alcohol and drug treatment providers to BIP training, because many of their clients are involved in DV as either perpetrators or victims. Changepoint has been the go-to place for co-occurring DV and substance abuse. Given the constraints of the real world, one thing that providers can do is to remain aware that not all of their clients have the same level of risk.

It's still taboo to show empathy or kindness to perpetrators, which makes it hard to advocate for their needs for other services, like individual counseling, career services, etc. The idea of funding these resources for perpetrators of IPV is frowned upon. Probation focuses on these services much more, with the intention of stabilizing perpetrators' contexts, which makes them less likely to offend. However, most perpetrators that BIP providers see have misdemeanors, as opposed to felonies, which means that there isn't as much money to get them the services that they need.

It looks like there are a lot of unrealistic options for providing tailored services for high-risk offenders, but it's hopeful to look back at the alcohol treatment field to see how far that movement has come in the last 40 years. It never occurs to BIP participants to advocate for services for themselves, like people in the alcohol treatment movement have done. It never occurs to clients that they have any social influence because of the stigma that they are up against. If folks went to Salem to advocate for services for BIP participants, we could certainly find participants to join them, though the initiative would have to come from providers. This is unlikely, however, because so many providers work part time in the field, and don't have the resources to invest in it. *Unclenching our Fists* is a recent book that includes interviews with 11 perpetrators, as a rare example of men speaking up about the importance of BIPs and their work therein.

Another hot topic related to funding is whether health insurance should be billed. Allies in Change is one of the few agencies that does bill insurance. Some BIPs are opposed to it. The amount that programs would receive from insurance is minimal, and most mandated BIP participants have terrible insurance, so they'd be paying out of pocket anyway. However, it might still be worthwhile to consider, because the more clients that we can get into BIPs, the more the stigma will deteriorate. We ought to reconsider whether it's worth maintaining the stance that perpetrators have to pay [financially] for what they've done, at the cost of their inability to attend to the program.