Tri County Batterer Intervention Provider Network Meeting Minutes May 14th, 2013

Attendance: Chris Huffine (Allies in Change), Regina Rosann (ARMS), Jennifer Hopkinson (Clackamas Women's Services), Mark Amoroso (MEPs Counseling), Brian Valetski (Dept of Community Justice, DV unit), Tammie Jones (OJD), Samantha Naliboff (VOA Home Free), Emmy Ritter (Raphael House of Portland), Ella Smith (ChangePoint), Jeff Hartnett (ChangePoint), Jacquie Pancoast (Central City Concern/ChangePoint), Annie Neal (Multnomah County DV Coordination), Debbie Tomasovic (A Better Way Counseling), Charley Zimmerman (Pacific University/Allies in Change), Wendy Viola (Portland State University), Jaime Chavez (Cedar Counseling Center)

Minutes by Wendy Viola, edited by Chris Huffine

Topic: Evidence-Based Practice: What is our understanding, what are its benefits and downfalls?

What is our understanding of the definition of evidence-based practice? Evidence-based practice means that someone has done research and established that a certain practice generates outcomes. That practice is then implemented widely with some fidelity. The phrase can be used in a couple of different ways: to refer to a practice that's been informed by empirical research conducted elsewhere or by others, or to refer to evidence established through individuals' evaluations of their own programs. The latter seems problematic. Another important qualifier for evidence-based practice is that the evidence cannot be established by just one study, there needs to be a body of research for something to be considered evidence-based.

There are different levels of being grounded in evidence: evidence-based, promising practices, best practices/gold standard, and evidence or theory – informed practices. Promising practices are yet to be empirically validated, but they make sense, based on relevant theory and their relation to other practices. Evidence or theory-informed practices are also yet to be supported by empirical evidence, but are based in relevant theory. For at least mental health interventions, there is a technical definition and classification for being evidence-based, such that practices that have been established as evidence-based are readily searchable.

The phrase "evidence-based" is often misused, as everyone would like that "Good Housekeeping gold seal of approval". As a result, people can be quick to use the phrase without full support or understanding.

Senate Bill 81, passed a number of years ago, required that most of the agencies receiving state funding had to offer evidence based practices. This included agencies receiving money from probation or child welfare, including batterer intervention providers. The tool most typically used to determine whether an agency qualified as using EBP was the Correctional Program Checklist (CPC) developed by Ed Latessa. Ed Latessa is an outspoken advocate for the use of evidence-based practice, and created the Correctional Program Checklist (CPC) and Effective Practices in Community Supervision (EPICS). Latessa conducted a very large literature review

to identify practices that are evidence-based. He summarized these findings in the CPC, which could be used to determine if a program serving corrections clients qualified. There are a number of problems in applying the CPC to batterer intervention programs, as not many BIP participants fit the profile for other criminal offenders. Please refer to an Tri-County BIP Network meeting minutes from 3/21/2006 for more information about this.

Most people in the DV field, including Gondolf, would say that we do not yet know what works. Early on, practices are more theory informed or philosophy informed than evidence-based, and that's where the BIP field is currently. There is not a lot of research supporting specific aspects of BIP practice. Attaining the status of being evidence-based begins with having a theory or philosophy of what works, which is usually generated from the wisdom of people who do the work on the ground. Those practices are then empirically tested and revised and changed based on the empirical results. We are just in the earliest stages, still, of that process.

There is no one shining program, doing a gold-star job, though Duluth (DAIP – Domestic Abuse Intervention Project) is likely the closest. Other successful programs include Emerge (the oldest BIP in the country) and AMEND.

The most widely used BI curriculum is the Duluth curriculum, parts of which are used by many providers. There is not yet strong empirical support for the Duluth curriculum. Because it has become the most well-known curriculum and is even required by some states, there has been a fair amount of criticism and backlash to it. Unfortunately, some of the backlash and criticism is coming from individuals who do not have a good understanding of it. For example, it has been criticized for not doing skill building (which it does) and because it does not involve empathy for participants (which it does).

Some of the reactions against Duluth may actually be against another curriculum, the New York model. For example, the New York model does not believe in skill building and typically displays no compassion at all to the participants. The New York model is a pure accountability model, maintaining that men know how to be non-abusive and that they can choose to be non-abusive at any point. The New York model places a large emphasis on showing up on time, having payment, etc., and there's no talk about feelings or what goes on in participants' lives outside of the group, as that could be construed as making excuses. Some feel that those who use the New York model are very resentful of their participants and feel very negatively towards them. Gurusava Mason is familiar with the model.

<u>Common curriculum items/practices</u>
There is no written consensus of professional guidelines within the BIP community. Still, the group identified some common standards of care, or widely accepted practices for working with abusive men, among batterer intervention in the U.S. and Canada probably include the following:
-addressing accountability
-clarification work (making clear what exactly happened during abusive episodes, with a focus on the arresting incident)

-addressing faulty beliefs
-empathy-building
-building discrepancy between what clients wanted or were hoping to achieve, and their actual behavior
-focusing primarily on the present as opposed to attempting to reconcile things from childhood
-working with single-sex groups
-utilizing a feminist or gendered analysis
-coordinating services with the referral sources, including providing at least some basic information such as attendance, if not more
-acknowledgement that there are victims of the abusive and how they are impacted
-a recognition that abuse is about power and control
-an educational component
-discussing different types of abuse
-addressing the effects of abuse on others (which is qualitatively different than empathy building)
-talking about rationalization
-maintaining that abusive behavior is always a choice and not accepting drug/alcohol abuse as an excuse
-battering is considered its own distinct issue just as addiction is its own distinct problem, meaning that while other issues may aggravate or escalate abuse (e.g., intoxication) they do not cause the abuse

<u>Some BIP practice areas lacking consensus</u>
One area of continued strong disagreement is whether BI is education/intervention or therapeutic/treatment. What further muddies this and that many programs make use of both more educational aspects (e.g., types of abuse) as well as therapeutic concepts (e.g., time-outs, noticing physiological warning signs, communication skills, etc.).

There is *not* a standard of care regarding domestic violence evaluations. Most providers do not do evaluations. In Clark County, however, most providers do DV evaluations, although some have deep reservations about this process. For programs that choose not to do evaluations, there is typically a presumption that because they have been mandated, we assume that clients are perpetrators instead of trying to identify which participants are offenders and which are not. For more information about domestic violence evaluations, refer to the 1/12/2010 Tri-County BIP minutes.

Risk assessment is surprisingly *not* a standard of care. Many providers do not routinely do formal risk assessment.

The length of the program is *not* standard, some states have programs that are 12 or weeks up to as many as 52 sessions. There is some speculation that more frequent meetings for a shorter duration would be more effective, as men are more likely to reoffend earlier on in treatment, so maybe we should concentrate our efforts in the first part of treatment.

There is also diversity in how providers approach partner contact. Our state standards include some degree of partner contact, but not all standards do.

There is also a diversity of ways BIPs are funded. According to the statewide directory, most Oregon BIPs are considered non-profits, which seems inaccurate to some. There was likely a problem with the phrasing of the question that was used to determine non-profit status. In Massachusetts and Florida, these programs are housed within public health departments, which enables greater coordination. There is actually funding for BIPs in Massachusetts.

There is also no standard of care in terms of whether a program is "working". We haven't been able to agree on how to define "working" for the purpose of determining whether programs are working: is it re-arrest? Victim reports? As assessed at one year out of treatment? Twenty years out? We can't speak with participants' or former participants' current or future partners, so we can't know about all of their potential abusive behavior. Depending on the methods and outcome variables used in a given study, conclusions can be vastly different. Hence, we can't really say that BIPs work or don't work. We can say that there is a modest effect for BIPs. But there is so little that we can generalize about BIPs. Instead, we need to ask about what *aspects* of programs work or don't work. We're not yet at the point of asking whether or not we should get funding, instead we're still trying to determine whether or not we should exist.

If we don't yet know what works in our field, one approach is to look at what providers in other fields are doing. For example, what programs in the sex offender field are doing. Sex offender treatment is primarily treatment, though it has many of the components of BIPs that we've identified today (e.g., group modality, confrontational, accountability focused, etc.). Part of the problem is that BIP providers can be pretty isolated and we are not particularly receptive to learning about what other fields are doing. Many providers do not keep abreast of research in their own field, let alone other fields. Just one example is that very few people have signed up for the advanced training being offered by Allies in Change next week. While money may be partly an issue, that doesn't explain why more providers don't attend this meeting, which is free. What could we do to get people more interested? If the state standards, which include a continuing education requirement, had more teeth, there would likely be a significant increase in attendance at these meetings as well as other training.

Socially and politically, there's more agreement that sex offending is bad and needs to be addressed. It's a little less clear-cut in the case of DV. There just isn't the money to be a BIP provider full time, whereas there is the money to do sex offender treatment or alcohol abuse treatment full time. In being able to do the work full time there's more incentive and desire to attend training and keep current on the research. We don't know what works, and we're not getting support to figure it out, in part because, since we don't know how BIPs work, there is a resistance to funding research on BIPs. There was one big grant right after the OJ Simpson trial, which Gondolf received and used to do a ton of research, but that's the extent of it. The general public doesn't think that DV is a problem, and especially not a problem that affects them, and as a result, there is less of a willingness to fund DV research and intervention. As evidence, there

has been so much pushback against making programs longer that they were effectively shortened.

We've been treating sex offenders and DV offenders as two distinct groups, but sex offenders could be a subset of DV offenders. However, a lot of sex offenders don't perpetrate DV. While many DV offenders have perpetrated sexual abuse, but it's not the level of sexual abuse that would elevate them to the level of a sex offender. But almost all sex offenders engage in some degree of controlling behavior. The sexual assault field has been folding in more interventions from other aspects of criminal behavior because sexual assault is cross-cut by so many other types of offending. In the 1980's a lot of research was done on convicted rapists, which is such a small subset of sex offenders, many of whom are incarcerated. In the SO field, there's an understanding that the bulk of offenders are totally missed by the system, and some of us believe that the opposite is true of DV (the general public believes that the majority of perpetrators are caught). When you ask a community sample if they've ever engaged in certain behaviors that are not explicitly identified as DV or SO, less DV behavior is endorsed than SO behavior.

Most providers see very few voluntary BIP participants. Lundy Bancroft who has written a number of books on perpetrators believes that a truly voluntary man cannot change. There are a few voluntary sex offenders, but you don't really know what you're working with in those cases. Within the SO field, recidivism also varies dramatically by offender sub-type. How SO's are classified is highly contentious, and there is currently some movement there.

Not being open to research creates a risk of becoming dogmatic. In the case that providers don't know for sure that their practices are evidence based, there is a chance that they are actually doing harm. However, it's also important to make sure that there is room for flexibility for providers to develop relationships with their participants, but first and foremost, it's crucial to make sure that no harm is being done. There is some practice-based evidence that providers learn themselves, particularly when it comes to working with cultural groups.

Qualitative research is a great place to start exploring which practices are most effective, especially because there are some things that are very hard to measure with standard experimental designs. However, qualitative research is often more difficult to use in establishing that a practice is evidence-based.

What would it take to spur some research locally? Challenges include determining what will be used to determine whether programs "work," tracking participants, trying to reach and collect information from victims, convincing IRB's that conducting research in this area is not prohibitively dangerous, and tension between researchers and the field.

Canadian programs are very innovative, including in the ways that they work with victims. Things are done very differently outside of North America. Do we know how well those methods work? There's a lot going on in England and Australia, but there isn't much going on in the rest of Europe in terms of BIPs. One interesting difference is that most of the abusive men

seen in programming in North America is mandated, while most of the abusive men seen in programming in other parts of the world are voluntary. One of the reasons that we're largely working with court-mandated men is that most forms of physical DV is illegal, which isn't necessarily true elsewhere. There are tribal interventions, more community-based interventions in other places as well. These interventions are often more successful by some definitions of success (in terms of victim safety). Even within the US, when we look at interventions within cultural groups, they look very different, and they're sometimes provocative because facets can stand in opposition to what we accept as common practice. The social concept of the problem is so different in other countries, where there are more voluntary men.

There is no real evidence-based practice in the DV field, including the Duluth curriculum. CBT is evidence-based in other fields, but not within BIPs specifically. There is more evidence around treatment modalities, but not as much around more activist or interventionist aspects of BIP work. Ultimately, we don't have any evidence-based practice for BIPs, and it will probably be another couple of decades before we do. But we can certainly use evidence-informed work, which involves drawing on the wisdom of the field. There's still a place for philosophy or theory, which is what the grassroots movement is about. There are different models in different fields that have been proven and that have been learned through experience, and there is certainly a place for that wisdom and experiential learning in BIPs.