Washington State Institute for Public Policy

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WHAT WORKS TO REDUCE RECIDIVISM BY DOMESTIC VIOLENCE OFFENDERS?

In Washington and across the United States, courts often order offenders charged with domestic violence (DV) crimes to attend DV treatment. Attending DV treatment may be a condition of a sentence handed down by a judge or a requirement of a deferred disposition.

The 2012 Washington State Legislature directed the Washington State Institute for Public Policy (Institute) to update its systematic review of the national and international literature on the effectiveness of DV treatment programs.[1] The Institute had previously found that DV treatment has little or no significant impact on repeat domestic violence (recidivism).[2] Other researchers have reached similar conclusions.[3]

In this report, we update and extend our earlier review to include other types of DV interventions. The Institute was directed to conduct the review of the DV literature in collaboration with the Washington State Supreme Court Gender and Justice Commission and experts on domestic violence.

The 2012 Legislature also asked the Institute to survey other states regarding legal requirements for DV cases, and to report recidivism rates of Washington's DV offenders (see box, page 2).

This report first presents findings from our review of the literature to determine "what works" to reduce recidivism by DV offenders. Second, we report the results from our survey of other states regarding the legal requirements for DV treatment. Recidivism rates will be presented in an upcoming Institute report to be published later in January 2013.

Summary

The 2012 Washington State Legislature directed the Washington State Institute for Public Policy to: a) update its analysis of the national and international literature on domestic violence (DV) treatment; b) report on other interventions effective at reducing recidivism by DV offenders and criminal offenders in general; and c) survey other states' laws regarding DV treatment for offenders.

Similar to 25 other states, Washington's legal standards for DV treatment require treatment to be group-based and incorporate elements of a treatment model developed in the 1980s in Duluth, MN.

In updating our review of the literature, we identified 11 rigorous evaluations—none from Washington—testing whether DV treatment has a cause-and-effect relationship with DV recidivism. Six of those evaluations tested the effectiveness of Duluth-like treatments. We found no effect on DV recidivism with the Duluth model. There may be other reasons for courts to order offenders to participate in these Duluth-like programs, but the evidence to date suggests that DV recidivism will not decrease as a result.

Our review indicates that there may be other group-based treatments for male DV offenders that effectively reduce DV recidivism. We found five rigorous evaluations covering a variety of non-Duluth group-based treatments. On average, this diverse collection of programs reduced DV recidivism by 33%. Unfortunately, these interventions are so varied in their approaches that we cannot identify a particular group-based treatment to replace the Duluth-like model required by Washington State law. Additional outcome evaluations, perhaps of the particular DV programs in Washington State, would help identify effective alternatives to the Duluth model.

This report includes separate statements from the Washington State Supreme Court Gender and Justice Commission and the Northwest Association of Domestic Violence Treatment Professionals.

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[1] RCW 26.50.800

[2] Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes, April 2012 update* (Document No. 12-04-1201). Olympia: Washington State Institute for Public Policy.

[3] Klein, A. R. (2009). *Practical implications of current domestic violence research: For law enforcement, prosecutors and judges*. Washington, DC: Office of Justice Programs, U.S. Dept. of Justice; Feder, L. & Wilson, D.B. (2005). A Meta-Analytic Review of Court-Mandated Batterer Intervention Programs: Can Courts Affect Abusers Behavior? *Journal of Experimental Criminology*, 1(2): 239-262; Babcock, J.C., C.E. Green, and C. Robie. (2004). Does batterers treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review* 23(8): 1023-1053.

I. WHAT WORKS TO REDUCE RECIDIVISM BY DV OFFENDERS?

BACKGROUND

Washington State law defines domestic violence broadly as acts or threats of physical harm, sexual assault, or stalking by one household or family member against another household or family member.[4] For this study, however, we use a narrower definition of DV, limited to violence between intimate partners, where the perpetrator is an adult male. While some women physically abuse their intimate partners, the vast majority of those prosecuted for DV are male.[5]

DV offenders may be ordered to attend a DV treatment program as a condition of a sentence handed down by a judge or as a requirement of a deferred disposition.[6] Typically, the offenders are responsible for paying the costs of treatment. Based on a brief survey in Washington, we estimate the average cost of treatment to be $1,365 per person.[7]

Judges report two main reasons to order DV offenders to treatment: first, to hold offenders accountable for the crime for which they were convicted; and second, to reduce the likelihood of future crime through the anticipated rehabilitative effects of DV treatment. In a national survey of the courts, 75% of judicial officers who order DV treatment consider it to be a form of accountability; 90% also do so with the goal of rehabilitation.[8]

It is important to note that this report focuses solely on the question of "what works" to reduce recidivism—that is, the degree to which DV treatment rehabilitates offenders to reduce future crimes. We do not address the use of DV treatment as a form of accountability.

Legislative Study Direction

The 2012 Legislature directed the Institute to do three things:

1) In collaboration with the Washington State Gender and Justice Commission and experts on domestic violence, "…review and update of the literature on domestic violence perpetrator treatment, and provide a description of studies used in meta-analysis of domestic violence perpetrator treatment. The institute shall report on other treatments and programs, including related findings on evidence-based community supervision, that are effective at reducing recidivism among the general offender population."

2) "The institute shall survey other states to study how misdemeanor and felony domestic violence cases are handled and assess whether domestic violence perpetrator treatment is required by law and whether a treatment modality is codified in law."

3) "…report recidivism rates of domestic violence offenders in Washington, and if data is available, the report must also include an estimate of the number of domestic violence offenders sentenced to certified domestic violence perpetrator treatment in Washington state and completion rates for those entering treatment."

Engrossed Substitute House Bill 2363, Laws of 2012.

Current Washington State Laws and Rules on DV Treatment. Current Washington State criminal law and administrative rules specify aspects of what is called the "Duluth model" of DV treatment for state-certified DV perpetrator treatment programs. The laws and rules prohibit substitution of other non-Duluth approaches to DV perpetrator treatment. Specifically, certain approaches cannot be used in place of the Duluth model, including individual, couples, or family therapy; substance abuse treatment; or anger management.[9]

The Duluth model is a commonly used intervention throughout the United States, Canada, and Great Britain for males charged with misdemeanor domestic violence. The intervention is based on a model developed in Duluth, Minnesota, in the early 1980's. The treatment approach assumes that domestic violence "...is a gender-specific behavior which is socially and historically constructed. Men are socialized to take control and to use physical force when necessary to maintain dominance."[10]

[4] RCW 26.50.010

[5] In Washington, from 2004–2006, 77% of DV offenders were male. See: George, T. (2012). *Domestic violence sentencing conditions and recidivism.* Olympia: Washington Center for Court Research, Administrative Office of the Courts.

[6] Ibid

[7] This is the middle of the range of costs based on a survey of seven treatment providers in Olympia, Seattle, Bellingham, Yakima, Spokane, and Moses Lake on June 2011. All offenders were on probation; program costs do not include the cost of probation.

[8] Labriola, M., Rempel, M., O'Sullivan, C., & Frank, P. B. (2007). *Court responses to batterer program noncompliance: A national perspective*. New York: Center for Court Innovation.

[9] WAC 388-60 and RCW 26.50.150

[10] Ganley, A. (1996). Understanding domestic violence. In: W. Warshaw & A. Ganley (eds.), *Improving Health Care Response*

Further, the model assumes that DV does not result from mental illness, substance abuse, anger, stress or dysfunctional relationships.[11]

In this report, we review the evaluation literature on the degree to which the Duluth model, as well as other forms of DV treatment, impact recidivism.

METHODS

The Institute has previously published extensive analyses of "what works" in criminal justice and other policy areas.[12] To accomplish the current legislative assignment, we systematically reviewed the research literature on DV treatments. We located 34 studies from throughout the United States and Canada that evaluated the effect of DV group-based treatment for male offenders on recidivism.[13]

It is important to note that this study is a systematic review of the literature, and is not an evaluation of whether specific group-based DV programs for male offenders in Washington State affect recidivism. Our approach is to review the national and international research literature to provide insight on the likely effectiveness of DV programs in Washington. To date, unfortunately, programs in Washington State have not been rigorously evaluated.

Most of the studies (30 of 34) evaluated male-only group treatment. The remaining four studies concerned couples group treatment for couples where men were the abusers. We found no outcome evaluations of interventions for female batterers.

After locating these 34 evaluations, we then applied our standard research design criteria for inclusion in our analysis. We assessed whether each study met minimum standards of research rigor. These criteria gave us confidence that any changes in outcomes are caused by the interventions and were not due to unknown characteristics or motivational factors of the program participants.

Research design. To be included in our meta-analysis, studies must have used a comparison group similar to the treatment group. We preferred studies where offenders were randomly assigned to treatment or comparison conditions, but we also included "quasi-experimental" studies that used appropriate statistical controls.

Some studies excluded from the analysis compared those successfully completing treatment with those who dropped out. While such designs have their advocates,[14] these study designs cannot control for the motivational factors and other risk factors associated with treatment completion. Compared to completers, dropouts are less likely to be employed[15] or married,[16] and are more likely to have an extensive criminal history[17] or severe psychopathology.[18] All of these characteristics are risk factors for recidivism.[19]

We also required that studies provided enough information to create effect sizes based on "intention-to-treat." That is, we only included studies where outcome information was provided for all those assigned to the treatment, not just those who completed the program. We adopted this rule to avoid unobserved self-selection factors that distinguish a program completer from a program dropout, since these unobserved factors are likely to significantly bias estimated treatment effects. We included a study reporting on completers only if the demonstrated rate of program non-completion was very small (e.g. under 10%).

Population. Our legislative assignment directs us to focus on criminal DV offenders. Therefore, we excluded studies where subjects volunteered or were ordered to treatment by civil court, as is sometimes the case in child custody cases.

Outcomes. To be included in our analysis, studies must have reported measures of criminal

to Domestic Violence (pp. 15-44). San Francisco: Futures Without Violence. Retrieved from http://www.futureswithoutviolence.org/userfiles/file/HealthCare/improving_healthcare_manual_1.pdf

[11] Ibid

[12] Lee et al., 2012

[13] The following rigorous evaluation was excluded from these analyses because it did not include a measure of DV recidivism: Chen, H., Bersani, C., Myers, S. C., & Denton, R. (1989). Evaluating the effectiveness of a court sponsored abuser treatment program. *Journal of Family Violence, 4*(4), 309-322.

[14] Gondolf, E. W. (2012). *The future of batterer programs: Reassessing evidence-based practice.* Boston: Northeastern University Press.

[15] Bennett, L., Call, C., Flett, H., Stoops, C. (2005). *Program completion, behavioral change, and re-arrest for the batterer intervention system of Cook County Illinois: Final report to the Illinois Criminal Justice Information Authority*. Chicago: Illinois Criminal Justice Information Authority.

[16] Ibid

[17] Ibid and Hanson, R.K. & Wallace-Capretta, S. (2000). *A multi-site study of treatment for abusive men*. User Report 2000-05. Ottawa: Department of the Solicitor General of Canada.

[18] Gondolf, E. W. (1999). MCMI-III results for batterer program participants in four cities: less "pathological" than expected. *Journal of Family Violence*, 14(1), 1-17.

[19] Ibid and Hanson & Wallace-Capretta op. cit.

recidivism. We preferred information from official police or court records. Frequently, studies on DV treatment measured recidivism from victim reports. If no official records were available, we included such studies if researchers were able to reach most of the victims. One study met this criterion.[20]

Reliability of the Review. To assure an accurate assessment of each study, two Institute researchers reviewed every evaluation. We also engaged the assistance of an external reviewer with extensive experience conducting systematic reviews.[21] Each reviewer independently read and coded each study. Final decisions regarding inclusion of studies were determined by consensus.

Calculating Effect Sizes (ES). After screening the 34 studies of group DV treatment for the inclusion criteria, we identified nine rigorous evaluations to include in our analysis. We then calculated an effect size (ES) for each study. The ES is a measure of how large the effect of the treatment is relative to the comparison group. We then combined the results from multiple studies to estimate the overall average effect size of the studies. This "meta-analysis" gives increased statistical power and allows greater confidence in the average overall effect of the intervention on recidivism.[22]

***Defining Promising Practice*.** The 2012 Legislature directed the Institute and the University of Washington's Evidence Based Practice Institute to develop definitions for "evidence-based," "research-based," and "promising" programs in the areas of children's welfare, mental health, and juvenile justice.[23] These definitions rank programs based on the strength of the evidence, with evidence-based programs considered to have the best evidence that the programs achieve desired results. Research-based programs have at least one rigorous evaluation but do not meet all criteria for evidence-based. "Promising" approaches are based on statistical analyses or a well-established theory of change. For all the studies reviewed in this analysis, we classified programs according to these definitions.

COLLABORATION

The Institute was directed to collaborate with the Washington State Gender and Justice Commission and experts on domestic violence. We met on four occasions with representatives of the Gender and Justice Commission. This report includes a statement by the Commission in Section III.

In early September 2012, we participated in the Seattle Domestic Violence Symposium. We also attended the annual conference of the Northwest Association of Domestic Violence Treatment Professionals (NWADVTP) in late August 2012, and met with representatives of NWADVTP on December 7, 2012. A statement from NWADVTP is included in Section IV.

FINDINGS

Our primary charge was to examine the effectiveness of DV treatment. The legislative study direction included a requirement to examine supervision and other options for the general offender population; the Gender and Justice Commission also expressed interest in other approaches. Therefore, we expanded our review of the DV treatment literature and present our findings based on the type of treatment approach, as follows:

A. Group-based DV Treatment
B. Other Approaches to Reducing Recidivism by DV Offenders
C. Interventions for the General Offender Population that may Apply to DV Populations

[20] Easton, C. J., Mandel, D. L., Hunkele, K. A., Nich, C., Rounsaville, B. J., & Carroll, K. M. (2007). A cognitive behavioral therapy for alcohol-dependent domestic violence offenders: An integrated substance abuse-domestic violence treatment approach (SADV). *American Journal on Addictions, 16*(1), 24-31.

[21] We contracted with Emily Tanner-Smith, Research Assistant Professor at the Peabody Research Institute and Department of Human and Organizational Development at Vanderbilt University. Dr. Tanner-Smith is currently the Associate Editor for the Methods Coordinating Group of The Campbell Collaboration, an international organization that prepares and disseminates systematic reviews in education, crime and justice, and social welfare.

[22] Following standard meta-analytic procedures, random effects inverse variance weights are used to calculate the weighted average effect size for each topic.

[23] The definition of "promising" is: a program or practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the "evidence-based" or "research-based" criteria, which could include the use of a program that is evidence-based for outcomes other than the alternative use. See: http://www.wsipp.wa.gov/rptfiles/E2SHB2536.pdf

A. Group DV Treatment

As mentioned, of the 34 studies of group treatment for DV offenders that we located, only nine studies met our inclusion criteria for analysis. Those nine studies include 11 effect sizes, shown in Exhibit 1.

In the table, negative effect sizes indicate that the program group had lower rates of recidivism than the comparison group. Thus, negative effect sizes indicate desirable outcomes for these programs.

The more negative the effect sizes, the greater the reduction in recidivism. For example, an effect size of -0.4 would indicate a greater reduction than an effect size of -0.2. Full citations for this group of studies are provided in Exhibit B1 in the appendix.[24]

Exhibit 1
Studies of DV Offender Group Treatment Included in the Meta-Analysis

Study	Location	Treatment Type	Treatment N	Duration	Comparison	Effect Size (p-value)* DV recidivism	Any recidivism
Davis et al., 2000a	Brooklyn	Duluth model	129	40 hrs over 26 wks	40 hr community service	-0.447 (p=0.01)**	N/A
Davis et al., 2000b	Brooklyn	Duluth model	61	40 hrs over 8 wks	40 hr community service	-0.091 (p=0.67)	N/A
Dunford, 2000a	San Diego Naval Base	Cognitive-behavior, focus on relationships, communication, empathy.	168	26 weekly sessions followed by 6 monthly sessions	No treatment	-0.066 (p=0.85)	N/A
Dunford, 2000b	San Diego Naval Base	Couples group therapy	153	26 weekly sessions followed by 6 monthly sessions	No treatment	-0.269 (p=0.50)	N/A
Easton et al., 2007	New Haven	Substance abuse treatment	29	12 weekly sessions	12-step program	-0.317	N/A
Feder, 2000	Broward County	Duluth model	227	26 weekly sessions	Probation only	-0.113 (p=0.68)	+0.320 (p=0.02)
Gordon, 2003	Virginia	Duluth model	132	20 or 24 wks	Probation only	+0.219 (p=0.20)	N/A
Harrell, 1991	Baltimore	Mixed, 82% were Duluth model	81	Varied 8 to 18 wks	Probation only	+0.490 (p=0.054)	N/A
Labriola et al., 2008	Bronx	Duluth model	173	26 weekly sessions	Probation only	+0.237 (p=0.12)	+0.089 (p=0.51)
Palmer et. al., 1992	Ontario Canada	Cognitive-behavioral, client-centered, focus on understanding violence, coping with conflict, self-esteem, relationships with women	30	10 weekly sessions	Probation only	-0.835 (p=0.06)	N/A
Waldo, 1988	East Coast US	Relationship enhancement therapy	60	12 weekly sessions	No treatment	-0.487 (p=0.20)	N/A

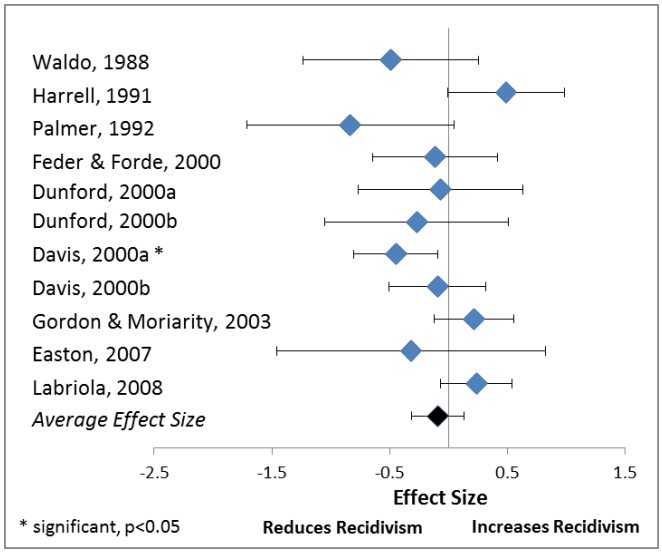
* p-values indicate the level of statistical significance. For example, a p-value of 0.05 indicates that five percent of the time we might expect to see the effect by chance
**Davis et al., 2000a showed a statistically significant impact on reduction.

[24] The 25 studies excluded from the analysis are described in Exhibits B2 and B3 in the Appendix.

Exhibit 2 displays the effect sizes (ES's) for each study and the combined ES for this group of studies.[25] In this "forest plot," the effect size is displayed along the horizontal axis. The diamonds show the effect size calculated for each study and the horizontal bars show the 95% confidence intervals—the statistical range of values that would contain the actual "true" value. If a study demonstrates a statistically significant effect, the confidence intervals would not include zero. In the collection of 11 effects included here, one (Davis, 2000a) is statistically significant.

We calculated a meta-analytic average for this combined group of studies—shown as the "average effect size" in Exhibit 2. The average effect size is not statistically different from zero. Thus, from this review of the most rigorous evaluations of group-based DV treatment, we would conclude that this form of treatment has no effect on DV recidivism.

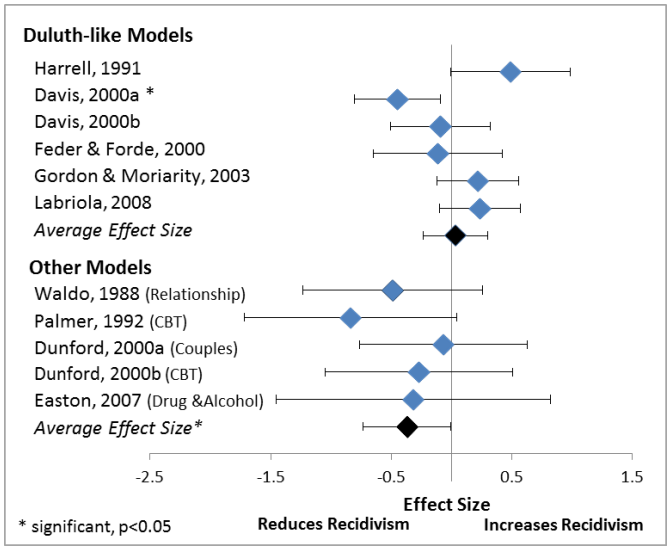
Exhibit 2
Effect Sizes for Group DV Treatment
Domestic Violence Recidivism



We then analyzed this group of studies to determine whether certain group-based approaches are more effective in reducing DV recidivism than others. We divided the 11 effect sizes into two categories: treatments based on the Duluth model, and those that used other methods.

The Duluth Group-based DV Treatment. We attempted to identify whether the treatments assessed in the 11 effect sizes were similar to the Duluth model. In some studies, the Duluth model was specifically identified. We also considered programs to be similar to Duluth if the study authors said the curriculum included "power and control" dynamics, "sex role stereotyping," or gender-based values. Six of the 11 effect sizes assessed Duluth-like programs. We analyzed separately the results of these six effect sizes and found that, on average, programs using Duluth-like models had no effect on recidivism (see the upper panel in Exhibit 3); therefore, this approach cannot be considered "evidence-based" (or research-based or promising).

Exhibit 3
Effects Sizes for Group DV Treatment
Duluth/Feminist and Other Models



Other Group-based DV Treatments. Of the 11 effect sizes, five were for rigorous evaluations of non-Duluth group-based DV treatment. These other treatments are a collection of various approaches, described on the next page. As displayed on the lower panel of Exhibit 3, individually, all of the programs reduced DV recidivism, but none of the alternative approaches had sample sizes large enough to achieve statistical significance.

When the studies are combined in a meta-analysis, however, the resulting larger sample size increases the ability to draw statistical conclusions. Thus, when these other non-Duluth models are analyzed as a whole, the combined effects indicate a statistically significant reduction in DV recidivism (the lower "average effect size" in Exhibit 3). The average effect was a 33% reduction in domestic violence recidivism.[26]

[25] Eleven effect sizes are displayed because two of the nine studies included more than one treatment modality.

[26] George, T. (2012). The Washington Center for Court Research indicates that 45% of all DV offenders commit another DV crime within five years. When the average effect size for the other (non-

It is important to note that some of these treatments are not appropriate for every offender. For example, substance abuse treatment would not be the treatment of choice for a DV offender who does not have substance abuse problems. Also, as noted earlier, under Washington State law, these treatments cannot be substitutes for Duluth-like DV treatment.

The "other models" shown in Exhibit 3 are described below.

- *Cognitive behavioral therapy.* Two studies (Palmer, 1992, and Dunford, 2000b) reported on similar cognitive-behavioral group treatments for DV offenders with emphasis on improving empathy, communication, and relationships with women.

- *Relationship enhancement.* One study (Waldo, 1988) examined men's groups for DV offenders where the focus is on improving their intimate relationships.

- *Substance Abuse Treatment.* The use of alcohol and/or other drugs frequently occur on the same day as domestic violence abuse.[27] We found one rigorous evaluation of a substance abuse treatment designed specifically for DV offenders (Easton, 2007).

- *Group couples counseling for DV offenders.* One approach to treatment is couples group counseling for couples wishing to stay together. One study included in the meta-analysis (Dunford, 2000a) showed a non-significant reduction in recidivism.

Duluth) DV treatments is applied to this recidivism rate, the DV recidivism rate reduces to 30%. This 15 percentage point reduction translates into a 33% (15/45) reduction in DV recidivism.

[27] Fals-Stewart, W., Golden, J., & Schumacher, J. A. (2003). Intimate partner violence and substance use: A longitudinal day-to-day examination. *Addictive Behaviors, 28*(9), 1555-1574; and Friend, J., Langhinrichsen-Rohling, J., & Eichold, I. I. B. H. (2011). Same-day substance use in men and women charged with felony domestic violence offenses. *Criminal Justice and Behavior, 38*(6), 619-633.

B. Other "Promising" Approaches to Reducing Recidivism by DV Offenders

The primary focus of our legislative direction was to search for evidence of effectiveness of DV treatment programs. The treatments just described are those with rigorous evaluations. We also searched the literature for other treatments not yet evaluated, as well as justice system approaches for DV cases.

The approaches, listed in Exhibit 4 (next page) and described in this section, can only be regarded as "promising," not evidence- or research-based.

Other Promising Approaches for DV Treatment. The following promising treatment approaches have not yet been evaluated.

- *Addressing Psychopathology*. In a multi-site study of DV offenders, 25% exhibited severe psychopathology.[28] Two mental disorders (described below) have been associated with severity of domestic violence.

  (1) Borderline Personality Disorder (BPD). A subset of DV offenders have characteristics associated with BPD.[29] Persons with BPD "attach themselves to others, then become intensely angry or hostile when they believe they are being ignored or mistreated."[30] Dialectical Behavior Therapy (DBT) is an evidence-based treatment[31] for BPD that is sometimes used with DV offenders exhibiting BPD symptoms.[32] To date, however, the effects on DV recidivism have not been evaluated.

  (2) Posttraumatic Stress Disorder (PTSD). Symptoms of PTSD are more common in abusive men than in non-abusive men.[33] In a sample of active military and veterans in a DV treatment program, greater severity

[28] E.W. Gondolf, E. W. (1999). MCMI-III results for batterer program participants in four cities: less "pathological" than expected. *Journal of Family Violence, 14*(1), 1-17

[29] For example, see: Dutton, D.G. & Starzomski, A. (1993) Borderline personality in perpetrators of psychological and physical abuse. *Victims and Violence, 8*(4), 327-337.

[30] Morrison, J. (1995). *DSM-IV made easy* (p. 478). New York: The Guilford Press.

[31] National Registry of Evidence-Based Programs and Practices. http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36

[32] Fruzzetti, A.E. & Levensky, E.R. (2000). Dialectical behavior therapy for domestic violence. *Cognitive and Behavioral Practice, 7*, 435-447; and Waltz, J. (2003) Dialectical behavior therapy in the treatment of abusive behavior. *Journal of Aggression, Maltreatment & Trauma, 7*(1)(2), 75-703.

[33] Dutton, D. (1995). Trauma symptoms and PTSD-like profiles in perpetrators of intimate violence. *Journal of Traumatic Stress, 8*(2), 299-316.

of symptoms of PTSD was associated with increased severity of DV.[34] While there are treatments that can reduce PTSD symptoms,[35] we were unable to locate any studies of PTSD treatment specifically for DV offenders.

- *Mind-Body Bridging*. This approach focuses on the mind-body state of the offender before his aggressiveness, which may be caused by lack of awareness and inability to modulate psychological and physical arousal.[36]

- *Moral Reconation Therapy (MRT) for DV*. MRT is one of several cognitive behavioral programs that have been shown to reduce recidivism; it is currently used by the Washington State Department of Corrections (DOC) for the general offender population. There is now a version of MRT specifically for DV offenders, but it has not yet been evaluated.[37]

- *Interactive journaling: Stopping Abuse for Everyone (SAFE)*.[38] Washington State DOC currently uses several cognitive-behavioral programs for general offenders, including an interactive journaling program, "Getting It Right!" The company that produces "Getting It Right!" has developed a version specifically for DV offenders. An evaluation of SAFE's effect on recidivism is currently underway.

- *Faith-based treatment for DV offenders*.[39] Religious individuals may turn to their churches for help in resolving family violence. Although faith-based programs for DV offenders exist, to date there have been no evaluations on the effects of such programs on DV recidivism.

Judicial System Approaches to DV. There are also criminal justice system approaches to reducing DV recidivism and increasing victim safety. The first four system options shown in Exhibit 4 (DV courts, judicial monitoring, specialized supervision, and GPS monitoring) have had a least one rigorous evaluation examining whether recidivism is reduced. The last two (Coordinated Community Response and DV risk assessment) have not been rigorously evaluated regarding their effect on recidivism. Each of these approaches is described below.

- *DV courts*. DV courts are specialized courts with separate calendars for DV cases and specially trained judicial officers. DV courts also frequently coordinate with victim advocacy services. To date, there have been only two rigorous evaluations of domestic violence courts, one for felons and another for misdemeanants. The evaluation of the felony court reported any new arrests (not specific to DV) and found an increase in re-arrests for those served by the DV court.[40] The study on the misdemeanor court reported a significant decrease in DV recidivism.[41]

- *Judicial monitoring* involves more frequent judicial contact, often within the context of DV court. A single rigorous evaluation of enhanced monitoring in a misdemeanor DV court found no effect on either re-arrests for any crime or re-arrest for DV.[42]

- *Specialized DV community supervision*. A single study on a specialized DV probation unit found that this approach reduced recidivism for lowest risk offenders, but had no effect on high risk offenders.[43]

[34] Gerlock, A. (2004). Domestic violence and post-traumatic stress disorder severity for participants of a domestic violence rehabilitation program. *Military Medicine*, *169*(6), 470-474.
[35] Lee et al., 2012
[36] Tollefson, D. R., Webb, K., Shumway, D., Block, S. H., & Nakamura, Y. (2009). A mind-body approach to domestic violence perpetrator treatment: Program overview and preliminary outcomes. *Journal of Aggression, Maltreatment & Trauma, 18*(1), 17-45.
[37] See https://www.ccimrt.com/materials/domestic-violence for more information.
[38] Dwayne Young , personal communication, September 14, 2012. The Change Companies is currently evaluating a modification of its offender program for domestic violence offenders. See: http://www.changecompanies.net/
[39] Nason-Clark, N., Murphy, N., Fisher-Townsend, B., & Ruff, L. (2003). An overview of the characteristics of the clients at a faith-based batterers intervention program. *Journal of Religion and Abuse, 5*(4), 51-72.
[40] Newmark, L., Rempel, M., Diffily, K., Kane, K.M. (2001). *Specialized felony domestic violence courts: Lessons on implementations and impacts from the Kings County experience*. Washington DC: Urban Institute.
[41] Gover, A.R., MacDonald, J.M., Alpert, G.P., & Geary, I.A., Jr. (2003). *The Lexington County domestic violence courts: A partnership and evaluation*. National Institute of Justice Grant 2000-WT-VX-0015.
[42] Labriola, M., Rempel, M., & Davis, R. C. (2008). Do batterer programs reduce recidivism? Results from a randomized trial in the Bronx. *Justice Quarterly, 25*(2), 252-282.
[43] Klein, A. R., Wilson, D., Crowe, A. H., & DeMichele, M. (2005). *Evaluation of the Rhode Island Probation Specialized Domestic Violence Supervision Unit.* National Institute of Justice Grant 2002-WG-BX-0011.

Exhibit 4
Other Promising Approaches to Reducing Domestic Violence Recidivism
None of these approaches can be regarded as evidence-based at this time because there is insufficient rigorous research, but each approach meets the definition of a promising practice.

Type of intervention	Specific to a sub-population?	Number of rigorous evaluations?	Findings from available credible evaluations
Treatments			
Addressing psychopathology: Dialectical Behavior Therapy for Borderline Personality Disorder (BPD)	Yes (those with BPD)	None	N/A
Addressing psychopathology: Posttraumatic Stress Disorder (PTSD)	Yes (those with PTSD)	None	N/A
Mind-Body Bridging	No	None	N/A
MRT for DV	No	None	N/A
Interactive Journaling	No	None	N/A
System level			
DV Courts	No	Two	Mixed
Judicial monitoring	No	One	Small impact (reduced recidivism)
Specialized supervision	No	One	Mixed
GPS monitoring	Yes (those with protection orders)	One	Small impact (reduced recidivism)
Coordinated Community Response	No	None	N/A
Risk assessment	No	None	N/A

- *Global Positioning System (GPS) monitoring*. The use of GPS during the pre-sentence period allows better enforcement of court orders of protection. GPS monitoring also has the capability to quickly inform victims via text message if the offender ventures into locations prohibited by the order. In a multi-site study, in one site, DV recidivism was measured. At this same site, DV recidivism decreased. The study also found that arrests during the pre-trial period increased, which may indicate improved victim safety.[44]

- *Coordinated Community Response (CCR)*. The Duluth treatment model was developed as part of a larger community response to DV. CCR involves coordinated response to DV with collaboration among criminal justice agencies (police, courts, and prosecutors), human service agencies, and community corrections.[45] It is thought that such coordination provides support for victims and makes clear that the community will hold DV offenders accountable for their actions. To date there have been no rigorous evaluations of CCR (see list of excluded studies in Exhibit C3 in the Appendix).

- *Risk assessment*. In recent years, several tools have been developed to assess the risk of DV re-offense by DV offenders. Typically, police officers at the scene use the assessment to collect information about the DV offender. This information is used by police agencies, prosecutors, the defense bar, and judicial officers to help decide how to proceed with each

[44] Erez, E., Ibarra, P.R., Bales, W.D., Gur, O.M. (2012) *GPS Monitoring technologies and domestic violence: An evaluation study*. Report to the National Institute of Justice, Document 238910.

[45] Hart, B. J. (2005). *Coordinated community approaches to domestic violence*. Minnesota Center Against Violence and Abuse. Retrieved from http://www.mincava.umn.edu/documents/hart/cca/cca.pdf

case. Two such tools are in various stages of implementation and validation in Washington State (in Thurston County and the City of Seattle).

C. Interventions for the General Offender Population that May Apply to DV Populations

Evidence from Washington State suggests that many DV offenders commit crimes other than DV. A study of DV offenders in Seattle found that 60% of recidivism was for crimes other than DV.[46] Two recent studies from the Washington State Center for Court Research found that among DV offenders who re-offended, a large proportion did not have a new DV offense. For example, in one study, 70% of DV offenders re-offended; but only 45% had a new DV court case.[47]

The Institute was directed to report on "other treatments and programs, including related findings on evidence-based community supervision, that are effective at reducing recidivism among the general offender population." The Institute has previously published extensive analyses of "what works" to reduce the recidivism rate in the general offender population.[48] The purpose of this section is to describe elements of the Institute's previous work that may be relevant for policy focused on DV offenders.

Exhibit 5 summarizes those previous analyses,[49] and provides information on the number of studies included, the number of participants in the treatment group, the average effect size for each type of intervention, and the p-value. All but two of these interventions (case management without swift and certain sanctions, and other drug treatment – non-therapeutic communities) were associated with statistically significant reductions in recidivism.

Exhibit 5
Summary of WSIPP Reviews of Interventions for Offenders in the Community

Interventions for Adult Criminal Offenders	Last Updated	Number studies	Number in Treatment Groups	Effect Size	P-value
Offender Re-entry Community Safety Program (Dangerously mentally ill offenders)	Apr-12	1	172	-0.756	<0.001
Drug Offender Sentencing Alternative (drug offenders)	Apr-12	1	323	-0.272	0.013
Supervision with Risk Need and Responsivity Principles (moderate and high risk)	Apr-12	6	3,024	-0.307	<0.001
Electronic Monitoring (radio frequency or global positioning systems)	Apr-12	16	18,263	-0.165	<0.001
Mental Health Courts	Apr-12	6	1,424	-0.238	<0.001
Drug Courts	Apr-12	67	27,872	-0.249	<0.001
Drug treatment delivered in the community					
Therapeutic communities	Dec-12	8	5,043	-0.147	0.001
Other drug treatment (non-therapeutic communities)	Dec-12	9	109,461	-0.048	0.221
Case management for substance-abusing offenders					
Swift and certain sanctions	Dec-12	7	4,004	-0.232	0.003
Not swift and certain	Dec-12	13	2,786	-0.074	0.457
Drug Offender Sentencing Alternative (Property offenders)	Apr-12	1	264	-0.272	0.015
Cognitive Behavioral Therapy (moderate and high risk)	Apr-12	38	31,775	-0.144	0.001
Work Release	Apr-12	7	16,406	-0.084	0.029
Employment Training/Job Assistance	Apr-12	16	9,217	-0.074	0.020

[46] Babcock, J. C., & Steiner, R. (1999). The relationship between treatment, incarceration, and recidivism of battering: A program evaluation of Seattle's coordinated community response to domestic violence. *Journal of Family Psychology, 13*(1), 46-59.
[47] George, T. (2012). *Domestic violence sentencing conditions and recidivism.* Olympia: Washington Center for Court Research, Administrative Office of the Courts.
[48] Lee et al., 2012
[49] Lee et al., 2012; and Drake, E. (2012). *Chemical Dependency Treatment for Offenders: A Review of the Evidence and Benefit-Cost Findings* (Document No. 12-12-1201). Olympia: Washington State Institute for Public Policy.

We also provide more detail on community supervision below, as requested by the legislature.

Community Supervision of General Adult Offender Populations

To date, we have systematically reviewed[50] three areas within the adult supervision literature to determine "what works":

- Intensive supervision—surveillance only;
- Intensive supervision—with treatment; and
- Supervision using the "Risk Need Responsivity" model.

Our review found that intensive supervision without treatment has no detectable effects on recidivism rates. When evidence-based treatment is added to intensive supervision, however, we find a recidivism reduction.

In addition to our reviews of intensive supervision with and without treatment, we analyzed an emerging literature on a model of supervision that utilizes the principles of "Risk Need Responsivity" (RNR). This model was first developed by Canadian researchers in 1990 and is defined as follows:[51]

- *Risk principle*—utilize interventions commensurate with an offender's risk for re-offense.
- *Need principle*—target offender's criminogenic needs such as anti-social attitudes or substance abuse; and
- *Responsivity principle*—utilize interventions geared toward the offender's abilities and motivation (generally cognitive behavioral or social learning interventions).

Exhibit 6 displays the main findings from our literature review of community supervision of general adult offenders. The exhibit shows the percentage change in crime outcomes for each of the three types of supervision. We find that intensive supervision with surveillance only has a 0.16% increase in recidivism, while intensive supervision with evidence-based treatment reduces recidivism, on average, by 10%. When community supervision is delivered with the RNR model, we find a larger (16%) reduction in crime outcomes.

Exhibit 6
Supervision for Adult Offenders: Effect on Crime

Supervision Strategy	Number of Studies	N	Effect Size	p-value	Percentage Change in Crime*
Intensive Supervision Probation/Parole (surveillance only)	14	1,699	+.004	0.951	+0.16%
Intensive Supervision Probation/Parole (with treatment)	17	3,078	-.205	0.004	-10%
Supervision with Risk Responsivity Need model	6	3,024	-.303	0.000	-16%

* We calculate the percentage change in crime as an average reduction over a long-term follow-up of 15 years.
Citations of studies used in these analyses are provided in Exhibits D1, D1, and D3 in the appendix.

[50] Drake, E. & Aos, S. (2012). *Confinement for Technical Violations of Community Supervision: Is There an Effect on Felony Recidivism?* (Document No. 12-07-1201). Olympia: Washington State Institute for Public Policy.
[51] Andrews, D., Bonta, J., & Hoge, R. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17*, 19-52.

SUMMARY OF FINDINGS

Based on six rigorous outcome evaluations of group-based DV treatment for male offenders, we conclude that the Duluth model, the most common treatment approach, appears to have no effect on recidivism. This updated finding is consistent with our (and others') previous work on this topic.[52] There may be other reasons for courts to order offenders to participate in these Duluth-like programs, but the evidence suggests that DV recidivism will not decrease as a result.

There may be other group-based treatments for male DV offenders that effectively reduce DV recidivism. We found five rigorous evaluations covering a variety of non-Duluth group-based treatments. On average, this diverse collection of programs reduced DV recidivism by a statistically significant 33%. Unfortunately, these interventions are so varied in their approaches that we cannot identify a particular group-based treatment approach to replace the Duluth-like model required by Washington State law.

We also searched for evaluations of other approaches to reducing DV recidivism. Unfortunately, we did not find enough credible studies to categorize any specific approach as evidence-based. We did, however, identify a number of approaches to reducing DV recidivism that could be considered promising.

Some strategies that are effective for criminal offenders in general may work for DV offenders as well. The Institute previously published extensive analyses of "what works" to reduce the recidivism rate in the general offender population.[53] Many of these other approaches reduce recidivism and save more money than they cost. The same approaches, if implemented for DV offenders, may also reduce recidivism. Until these approaches are tested and evaluated with DV offenders, however, this can only be regarded as a tentative assumption.

It should also be emphasized that none of the rigorous studies in our review was conducted in Washington State. If the legislature wishes to learn whether Washington's programs are more effective than the non-Washington programs reviewed here, we recommend that rigorous outcome evaluations be conducted.

Treatment providers in Washington State report that, in addition to the legally required Duluth-like group-based model, they also provide other types of treatment, as described in Section IV of this report. Those other treatments could be assessed in a rigorous outcome evaluation. Through a series of outcome evaluations of Washington programs, it may be possible for Washington State to identify an evidence-based DV strategy.

[52] Lee et al., 2012; Klein, 2009; Feder & Wilson, 2005; and Babcock et al., 2004

[53] Lee et al., 2012

II. DV TREATMENT IN OTHER STATES

We surveyed other states to determine whether they mandate a specific type of treatment and other aspects of treatment. We found that 44 of 50 states currently have legal guidelines for DV treatment. In 28 states, standards for DV treatment specify the Duluth model by name, or require that power and control dynamics—central to the Duluth model—must be included in the treatment curriculum. In 12 states, the guidelines are less specific in mandating a curriculum or approach. The remaining four states have standards regarding intake and assessment but do not specify treatment type.

Appendix D provides the details of our survey methods and a state-by-state comparison of requirements for DV treatment.

III. STATEMENT OF THE WASHINGTON STATE SUPREME COURT GENDER AND JUSTICE COMMISSION

The Washington State Legislature passed HB 2363 which directs the Washington State Institute for Public Policy to:

- assess recidivism by domestic violence offenders
- examine effective community supervision practices as it relates to the WSIPP's findings on evidence-based community supervision; and
- assess domestic violence perpetrator treatment.

HB 2363 also directs WSIPP to collaborate with the Washington State Supreme Court Gender and Justice Commission. The intent of this collaboration is an acknowledgement of the challenges and complexity of reducing recidivism of domestic violence perpetrators so victims are safer and the pattern of abuse is severed. It is a community problem requiring a coordinated systemic problem solving approach. As Dr. Thomas George states in his report, *Domestic Violence Sentencing Conditions and Recidivism*, "Over the last few decades, a wide variety of statutory, procedural, and organizational reforms have been enacted throughout the legal system to combat the widespread and destructive effects of domestic violence."

While efforts attempting to identify effective domestic violence treatment programs should be applauded, a quandary still remains for the court system. Research hasn't identified which perpetrators need lengthy treatment and which ones don't, as well as who is amenable to treatment and who isn't. There is wide variance in the conditions set by the court so it has been difficult to determine the combination of conditions that will be the most effective in reducing recidivism. Thus, judicial officers are left unclear about what sentencing conditions to impose.

Dr. George researched the effect of a variety of sentencing conditions in a multitude of combinations. He found that "[f]rom imposing only fines and/or proscriptions to crafting sentences that involve fines, proscriptions, jail, assessment, treatment, and probation, little consistency exists both within and across jurisdictions." He concludes that this suggests a "lack of clarity and consistency in goals underlying domestic violence sentencing and reflects the ambiguous relationships between goals and sentence conditions. It highlights the lack of research evidence on successful approaches to reducing recidivism upon which judicial officers could base their decisions."

Dr. George's work reflects the legislative mandate that WSIPP "must collaborate" with the Commission. Because of the complexity of domestic violence, the solution is also complex and multifaceted. The HB 2363 report to the legislature must include this reality. More work is needed in this area to determine what role the courts can play in changing abusive behavior so that those victimized by it can feel safe.

Additional work needs to be done in exploring the potential combinations of sentencing conditions that seem to have a positive effect on recidivism and what resources are required by courts to implement these sentencing conditions. Currently, researchers are exploring the impact of judicial monitoring on reducing recidivism. Limited work has been done on identifying the different condition options and which combinations of conditions will be most effective. With the support of the legislature, the Commission is prepared to begin this work for Washington State.

All of the above addresses the "must collaborate" language in HB 2363. The Commission builds its work from the end of the research conducted by WSIPP. Our work will focus on identifying the policies and practices instituted within the court setting that have promise in reducing recidivism in domestic violence cases and as a result enhance safety for the victims.

IV. NORTHWEST ASSOCIATION OF DOMESTIC VIOLENCE TREATMENT PROFESSIONALS (NWADVTP) POSITION PAPER REGARDING DOMESTIC VIOLENCE TREATMENT IN WASHINGTON

This is in response to the research and meta-analysis required by RCW 26.50.800, which WSIPP, the Washington State Institute for Public Policy, has been conducting to evaluate the effectiveness of domestic violence perpetrator treatment in our state. There has been talk in some circles of turning over clinical work with perpetrators to the Department of Corrections Probation Officers, and local probation departments, or sending domestic violence perpetrators to short term anger management type programs. Another option being talked about is jail time for DV offenses with no other intervention. If these changes were to occur, it would effectively remove current Washington State Certified Domestic Violence Perpetrator Programs from providing treatment services to court ordered offenders. State Certified programs meet or exceed 25 pages of regulations in WAC 388-60 designed to maximize victim safety and perpetrator accountability. Our concern is that the manner in which the research is being conducted leads to erroneous conclusions. Those conclusions can be the basis for very dangerous policy decisions that undermine the safety of domestic violence victims and the accountability of perpetrators.

1. **Professional, independent review of the Meta-Analysis and other research required by RCW 26.50.800**. The NWADVTP has contacted professional domestic violence researchers to conduct an independent review of the research, and meta-analysis that is being conducted by Marna Miller, PhD and her team at WSIPP. We have grave concerns about a meta-analysis that only considers a dozen random controlled studies while excluding scores of well conducted, peer-reviewed research projects that show the effectiveness of Domestic Violence Treatment. Further, research that only focuses on legal recidivism misses a more complete picture of how peoples' lives are positively affected by a well-coordinated community response to domestic violence that includes a strong clinical perpetrator treatment component. Though WSIPP believes its standards for evidence lead to more reliable results, we do not believe that the methodology employed by WSIPP can take stock of the complexities of Domestic Violence. The idea of turning over Domestic Violence Treatment to the Department of Corrections and local probation departments is an idea that has not been adequately researched or discussed by all concerned parties. And without such dialogue and research, such a shift in policy can have dangerous and unexpected results.

We believe that victims truly can be safer with quality perpetrator treatment, and we believe that the best research bears this out. Community Corrections Officers and Probation Officers do a great job, but they do not have the clinical background and training to provide effective treatment to domestic violence offenders.

The professionals that we have contacted for review are: Eric Mankowski, PhD, Portland State University; Donald Dutton, PhD, University of British Columbia, Canada; and Edward Gondolf, PhD, University of Indiana.

2. **Domestic Violence is not a simple issue**. Most cases are very complex with many offenders that we see in treatment presenting with multiple issues. The current standards outlined in WAC 388-60 give us minimum guidelines for treatment, and are up for review. Around 80 % or so of our offender clients have Chemical Abuse/Dependency issues at some level. Approximately 1/3rd of offender clients have some Mental Health issues including personality disorders. Most offender clients have Power & Control issues, and underlying those issues are:

a. Attachment Disorders.
b. Toxic Shame/Guilt from childhood.
c. Trauma issues from physical, emotional, and sexual abuse as a child.
d. Trauma issues and PTSD from War, and Family of Origin.
e. 85% of male offenders, and close to 100% of female offenders have experienced or witnessed Domestic Violence in their Families of Origin.
f. Dependency/Co-Dependency issues.
g. Fear/Insecurity/Low Self-Esteem issues.
h. Many offender clients lack life skills, and coping skills.
i. Lack of emotional development, emotionally stunted.
j. Externally focused orientation to life with little, if any, internal focus.

It has been found with most offenders that there is a large amount of denial, minimization and blaming that takes a considerable amount of time to work through. It often takes around three months or so of weekly treatment sessions to allow for a reduction in denial, minimization, and blaming. The above listed issues become a part of the offender's treatment plan. Those offenders with multiple issues as indicated above may need more than one year to address them effectively. If the above issues are not adequately addressed in treatment, the violence is likely to continue and new generations will be exposed to more violence. Short term interventions do not provide enough time or therapy to work through basic issues of denial, minimization or blaming, much less the other pieces necessary for significant and lasting changes in behavior. Arresting, and prosecuting without follow up intervention only aggravates the situation by putting the victims in more danger.

3. **An effective Coordinated Community Response to Domestic Violence** requires that all parties involved in Domestic Violence intervention communicate, and cooperate with each other on a regular on-going basis. The major components of a Coordinated Community Response have historically been the Criminal Justice System, Victim Advocacy Services, and Domestic Violence Treatment Providers. There have been others in the community that have also been a part of this response such as Faith Based Communities, Employers, Violent Crime Victims Advocates, and others providing adjunct services like Chemical Dependency Treatment, Mental Health Services, Non-Violent Parenting Programs, etc.

Most cities, and counties around the State of Washington have meetings in which the members of the Coordinated Community Response come together, at least once per month, to discuss issues with services that are needed in those communities. Those Domestic Violence Intervention Committees (DVIC's), Taskforces, or Commissions have helped to keep the Coordinated Community Response moving in a positive, healthy direction. Many of these groups have been meeting for many years. One of the oldest groups is the Tacoma/Pierce County DVIC which has been meeting regularly since 1989

Over the past few years, we have seen a deterioration of some of those groups, and the overall effectiveness of a Coordinated Community Response in many communities around the State of Washington due in part to the economy and shrinking resources. This deterioration has put more victims of domestic violence at risk, and our overall numbers of domestic violence crimes in the State of Washington have been steadily increasing since 2008 according to WASPC statistics.

We do realize that financial concerns and other priorities have contributed to the deterioration of the Coordinated Community Response. In some communities key players in the Coordinated Community Response are volunteering their time to continue the meetings that are so necessary in maintaining an active Coordinated Community Response to Domestic Violence.

We believe that the right of all human beings to live safely, and peacefully should be the number one priority in all our communities. We need to not lose sight of our priorities if we are to help keep victims safe.

4. **RCW 26.50.150 and WAC 388-60 set the minimum standards for Domestic Violence Treatment**. Certified Domestic Violence Perpetrator Treatment Programs are mandated to adhere to WAC 388-60, but they also have some leeway as to how these standards are implemented by programs. This is as it should be so that offenders can choose a program that fits their needs as is regulated by Federal Statute.

Washington State Department of Health and other regulatory agencies have never been allowed to show preference of one mode of therapy over another. Such decisions are left up to the professionals providing the services, as long as the requirements of the statutes are fulfilled.

At times, some people have promoted specific models of treatment and modes of therapy implying that somehow one is better than another. There is little evidence to prove their case. It is more likely that the therapist-client therapeutic bond would be a better indicator of the client's success in making behavioral change than what mode of therapy is being employed. It has been effectively shown that punitive forms of treatment do not work as they interfere with the establishment of a therapeutic bond, and they model the same inappropriate behaviors that we are attempting to have our client's correct in their own lives.

Many certified programs in the State of Washington use a mode or model of therapy that is Cognitive Behavioral Based with some other aspects of other models included as well. Most programs use a process oriented group therapy that allows for clients to process their issues in a group setting. There are also some culturally relevant treatment programs that include culturally specific elements and language into the treatment process. There are culturally relevant programs for Spanish Speaking Cultures, Native American Cultures, Russian-Ukrainian Cultures, and Afro-American Cultures.
Some of the modes of therapy used in treatment programs around the State of Washington include, but are not limited to:

a. Cognitive Behavioral Therapy (CBT).
b. Reality Therapy, and other versions of Reality type Therapy.
c. Developmental Therapy.
d. Adlerian Therapy.
e. Transpersonal Therapy.
f. Moral Reconation Therapy (MRT).
g. Culturally Relevant Therapies.
h. Trauma-informed Therapies.

There are also some adjunct types of therapy in addition to Domestic Violence Treatment that are beneficial to the success of our clients, such as:

a. Trauma Reduction Therapies (EMDR, Hypnotherapy, NLP, etc.).
b. Chemical Dependency Treatment and 12 Step Program Participation.
c. Alanon, Co-Dependency Anonymous, Adult Children of Alcoholics, Sex and Love Addicts Anonymous, as an adjunct or aftercare program, etc.
d. Mental Health Counseling/Medication.
e. Individual Therapy for PTSD, Personality Disorders, etc.

Most Domestic Violence Treatment Programs in the State of Washington require clients to complete homework assignments. Some of the assignments may include:

a. Writing and presenting of Life Story to the group.
b. Empathy Letter to the victim/victims.
c. Reports on certain topics/books pertinent to the client's recovery.
d. Recovery Plans/Safety Plans.
e. Cultural Stories to present to group.
f. Ceremonies/rituals to make change and reduce violence.
g. Anger and Control logs.
h. and many other types of assignments pertinent to the clients recovery.

Domestic Violence Treatment Programs have to address the serious problem of relapse of Chemical use as well as Behavioral Relapse. Though relapse is not a requirement for clients going through treatment, it seems to be problematic for some of our clients. This needs to be taken into consideration when doing research about recidivism. Some clients seem to need to prove to themselves that they have a problem. Relapse tends to happen for some clients before they make real lasting change. So, some clients will have their programs extended or re-start treatment more than once in some cases, and make several trips to see the judge or probation officer for violations of their agreement or for new offenses. Domestic Violence Treatment and lasting recovery from the perpetration of violence is a process that is on-going for the rest of the client's life. We need to realize that it is a process, and not a one time or short term event.

5. **Domestic Violence Treatment does work**. When there is a solid Coordinated Community Response treatment works very well for many people. Most treatment providers know this. It's why we continue to do this difficult and often thankless work. Providers are encouraged to have some way of measuring outcomes with their programs. Some programs have well thought out methods of tracking client outcomes. There has not been much real research done on treatment programs in the State of Washington. There needs to be quality research on all available programs to clearly see the validity and effectiveness of Domestic Violence Treatment. Most research has been done on other programs outside the State of

Washington with attempts to compare them to what we do in Washington. Not all programs are the same in length, content, or structure.

6. **Short term CCAP/MRT type programs have not been adequately researched to show their effectiveness in addressing Domestic Violence issues**. Some short term programs that have cropped up in the State of Washington have not been shown to be effective for long-term recovery from violence and abuse. Some programs see an offender anywhere from one or two sessions to maybe 20 sessions with no consistency in length or content. Many of these types of programs do not have time to address issues of denial, minimization, and blaming effectively, and they certainly don't have time to address the myriad of other issues. There seems to be a movement among some judges and attorneys to find different ways to address Domestic Violence issues. Looking for ways to improve the quality of Domestic Violence Intervention is what we all want, but without a solid understanding of the complexities of Domestic Violence we can end up with simplistic, ineffective solutions to very complex issues.

7. **What we see as valid outcomes of DV Treatment, and possible outcome based evaluations**. In addition to completing all of the requirements of WAC 388-60 and the treatment program contract, some programs around the state have developed tools to assist in measuring outcomes of perpetrator treatment. One such tool is the Perpetrator Index that was developed many years ago by the Tacoma/Pierce County DVIC, a work group of the Pierce County Commission Against Domestic Violence. The Perpetrator Index was developed with input from victim advocacy services, criminal justice system, and treatment providers. It is currently used by some programs around the State of Washington. There are probably other types of outcome evaluations being used in different parts of the state. We would like to see a collaborative effort to create a way to conduct outcome type research with treatment programs around the state. Documentation needs to go beyond recidivism looking at the reduction of negative behaviors and activities, replaced by positive behaviors and activities. Having verification of these behavioral changes from the victim and others in the client's life without placing the victim in a dangerous position would be an important part of this process.

8. **Possible solutions to current situation in DV Program supervision with DSHS, peer review, possible DOH Credentialing, and possible RCW and WAC revisions**. It is obvious to most people that the State of Washington has never put forth resources to adequately supervise and monitor Domestic Violence Treatment Programs. Additionally, people in those positions over the years have not possessed the experience or training needed to effectively supervise DV treatment programs (no offense to any of them). One of the requirements is to have experience working with Perpetrators of Domestic Violence in a State Certified Treatment Program. The people who are charged with Program Management at DSHS typically have worked alone, with no administrative or clerical help. They provide certification of programs, re-certification of programs, and investigation of complaints against programs. The DSHS Advisory Committee that is outlined in WAC 388-60 has not met in close to 15 years. The explanation that has been given has been that DSHS does not have the money to pay travel expenses to members of that committee. Most people would volunteer their time, and travel expenses to provide quality input to DSHS regarding Domestic Violence Treatment. There is no excuse for not having the Advisory Committee meet on a regular basis as is required by WAC 388-60.
The NWADVTP (formerly known as WADVIP) has over the years attempted to provide programs with Peer Review/Consultation (free of charge). We have also provided on-going continuing education in the form of Annual Domestic Violence Conferences (since 1994), and short term workshops where we bring in Domestic Violence Experts from the local community, and around the world to present on relevant issues, and new ideas on the Treatment of Domestic Violence. Presentations have been made by; Ellen Pence, PhD, Lenore Walker, EdD, Donald Dutton, PhD, Daniel Sonkin, PhD, Caroline West, PhD, Barbara Hart, PhD, and Oliver Williams, PhD just to name a few. With some local expert presenters such as: Anne Ganley, PhD, Roland Maiuro, PhD, April Gerlock, PhD, ARNP, and others from the Northwest. These trainings continue to be widely accepted and attended by treatment providers. The NWADVTP currently represents approximately 75 % of Domestic Violence Treatment Providers from around the State of Washington with some members from Oregon, Idaho, and British Columbia.

We believe that the current WAC 388-60 should be revised and updated as a means of continuing to improve the quality of clinical work done in Domestic Violence Treatment Programs in our state. Topics for discussion about WAC updates among all stakeholders could include:

a. Domestic Violence specific education/training requirements for potential providers (review or upgrade as needed).
b. Change the name of our organization from WADVIP to NWADVTP.
c. Re-activate the DSHS Advisory Committee as a volunteer committee.
d. Establishing standards for Family Court Evaluations, and Criminal Court Assessments.
e. Possible Peer Review/Consultation for Domestic Violence Programs.
f. Improved trainee and staff supervision.
g. Other possible changes as suggestions are submitted.

Washington State has been at the forefront of addressing the issues of Domestic Violence in all of its complexities, in order to create a safer community for all of our citizens, especially those who are most vulnerable. The State of Washington has been deemed as progressive by many in the Domestic Violence movement around the country. This is not a time to retreat from the gains that have been made over the last several decades in establishing an effective Coordinated Community Response to Domestic Violence: it is a time to build on those gains and move forward in a progressive manner. To do that will require hearing from all who are affected by and concerned about Domestic Violence. Nothing less than the best, fullest, and most accurate information is what will allow us to shape policies and practices that can truly help to end the on-going cycle of Domestic Violence in our community.

Respectfully,

NWADVTP Board of Directors

“Electronically Signed”
Steven C. Pepping, MA, CDP, DVP
Northwest Association of Domestic Violence Treatment Professionals, President

ACKNOWLEDGEMENTS

We are grateful to the Washington Supreme Court Gender and Justice Commission for meeting with us as we updated our systematic review of the literature.

The Northwest Association of Domestic Violence Treatment Professionals (NWADVTP) generously allowed time on their conference agenda to discuss our review of the treatment literature and the board of NWADVTP met with us in Olympia to discuss our methods for selecting studies to use in meta-analysis.

We thank Dr. Emily Tanner-Smith at the Vanderbilt University who served as a third coder to review studies to determine which met inclusion criteria.

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