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Batterer Intervention Programs: A Report From the Field

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Over the past 25 years, batterer intervention has become the most probable disposition following a plea or conviction on domestic battery charges and, consequently, batterer intervention programs (BIPs) have proliferated. Despite their popularity, and recent attempts by states to regulate practice, little is known about the actual programs operating in the field. The aim of this study was to examine the philosophy, structure, leadership, curricula, and support systems of BIPs. Respondents from 276 batterer intervention programs in 45 states described their programs via an anonymous, Web-based survey. The results provide some insight regarding the workings of actual BIPs and also point out problems such as the dearth of programs in languages other than English and the failure to translate recommendations for prescriptive approaches into practice.

Since 1980, through the efforts of the battered women's movement, intimate partner violence (IPV) has been increasingly recognized as a crime at the state, county, and city levels of legislation, leading to increased proarrest police policies, more vigorous prosecution, more convictions of, and guilty pleas by, batterers. Psychoeducational treatment programs (batterer intervention programs; BIPs) became widely utilized by courts in sentencing (Babcock & Taillade, 2000; Hotaling & Sugarman, 1986). Court-mandated treatment owed its popularity to the fact that in many cases the offense was at the level of a misdemeanor (and in many cases a first offense), which would not justify incarceration. Furthermore, incarceration also has negative consequences for victims, such as loss of income, social stigma, and a negative impact on any children (Davis & Taylor, 1999). Many victims remain with their partners and don't want their partner jailed (Hamberger & Hastings, 1993; Jennings, 1987; Snyder & Scheer, 1981). In most cases, jail sentences would be brief and there is little evidence in the criminology literature that incarceration serves a rehabilitative function (Boudouris & Turnbull, 1985). Treatment of batterers also holds out the possibility of preventing further violence by the offender.

At present, most states have enacted legislation empowering and encouraging the courts to utilize BIPs in sentencing and in some cases as a diversionary program. In this environment, the number of BIPs operating in the United States has increased exponentially. Gelles (2001) suggested that "it is reasonable to assume that there are thousands of treatment programs treating tens, if not hundreds of thousands of men each year" (p. 13). Gelles's speculation would appear to be reasonable, given that in 2006 there were more than 450 registered programs in California alone, serving more than 25,000 batterers (California State Auditor, 2006). The most recent study of state standards indicates that 45 states have enacted standards for BIPs (Maiuro & Eberle, 2008). In addition, many

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states have enacted a process of certifying programs that meet these standards. Thus, estimates of the number of programs in the United States are more likely to include certified programs, because they are catalogued by the states and it is more difficult to identify programs that do not comply with state standards. In any case, there is no nationwide registry of batterer intervention programs and we don't actually know how many there are.

Batterer intervention programs are often spoken of and written about as if they were all the same. This may be due to the fact that the literature on batterer intervention is dominated by very few treatment models, most commonly the Duluth model. Developed by Pence and Paymar, the hallmarks of the Duluth model are the coordinated community approach and the focus on power and control as the primary etiological factor in IPV (Pence & Paymar, 1993). Another common identifier applied to BIPs is "profeminist," which—in addition to a focus on power and control—connotes the philosophy that the victim, not the batterer, is the client, and protection of the victim, not necessarily rehabilitation of the batterer, is the treatment objective. The term "psychoeducational" also occurs frequently in program descriptions and may be used to convey that the program is nontherapeutic. In fact, the term "batterer intervention" is preferred over "batterer treatment" by many state standards (e.g., Massachusetts) in an effort to depathologize battering, remove intervention from the domain of the mental health professions, and to avoid diminishing the batterer's responsibility for violence (Pence & Paymar, 1993). Despite this, there are approaches rooted in the more traditional mental health domains that utilize mainstream group psychotherapeutic strategies and define themselves as cognitive behavioral or psychodynamic. Therapeutic programs are also more likely to define the batterer as the client and adhere to the ethical codes of the professions of their developers; however, they are no less committed to victim protection and violence cessation.

These descriptors are not mutually exclusive, and programs commonly identify themselves using various combinations of these terms. In reality, batterer intervention encompasses a wide variety of approaches, and even programs espousing similar philosophies and models may be very different (Healy, Smith, & O'Sullivan, 1998). Our knowledge of BIPs is derived from published descriptions (including treatment manuals) and research. However, the diversity of batterer intervention strategies may be poorly represented in this literature, as we know little about the actual practice of batterer intervention in the field.

In this article, we present the results of a survey of batterer intervention programs in the United States that was conducted to examine the actual practice of batterer intervention. It was first necessary to assemble the most comprehensive directory of programs possible. We began with a database given to us by Bruce Dalton, which he reported on in an article in the *Journal of Aggression, Maltreatment, and Trauma* (Dalton, 2007). This initial database included contact information for 2,012 programs. In addition, we contacted the agencies charged with oversight of batterer intervention programs in each of the states having standards and agencies in those states without standards (e.g., Department of Health and Family Services). In all, information regarding programs was collected from all 50 states. Each identified program was contacted by telephone and e-mail and was invited to complete an anonymous Web-based survey. One of the survey items asked for the names and addresses of any programs (certified or not) of which they were aware. This was done to identify uncertified programs that might not have been included in official directories. Ultimately, we developed contact information for 2,557 programs. The programs vary in structure, with some being stand-alone batterer intervention programs and others operating in conjunction with general mental health

clinics, counseling centers, religious organizations, victim shelters, or other programs (e.g., police department, YMCA).

The primary aim of this project was to shed light on what is actually happening at the practice level, using a nationwide survey of currently operating batterer intervention programs. We anticipated that programs might question our motives and be guarded regarding the answers to our more threatening questions (e.g., how closely they follow their state guidelines). Therefore, the survey was completely anonymous. The only identifying information was the state in which the program operated. The survey covered a multitude of topics including the number and source of referrals, program format, session and program length, group size, and group rules. There were questions regarding funding mechanisms and the credentials of group leaders. Program philosophy, curriculum, and participant characteristics were explored as well as confidentiality and program evaluation issues. To get a better idea of how effective and coordinated the community response really was, we included questions regarding the legal environment (relationships with police, prosecutors, and courts) in the areas in which the programs operated.

METHOD

Participants

The participants in this study were the representatives from the BIPs who responded to our request to complete the survey. Program directors were contacted by telephone and invited to participate, but individual programs were free to select their reporter. Of the 2,557 programs in the database, 1,890 were able to be contacted using the contact information on record. A number of programs did not answer telephone calls nor respond to messages left. After three unsuccessful attempts at contact, nonresponsive programs were removed from our database. Fourteen hundred of the 1,890 programs contacted agreed to receive participation details via e-mail. Of those, 276 programs (approximately 20%) from 45 different states completed the survey. Because the survey was anonymous and there was no way for us to tell which programs had responded, several follow-up e-mails were sent to all programs encouraging them to complete the survey.

The average number of responses per state was five. However, total number of programs and the number of responsive programs was not evenly distributed across states, hence several states are overrepresented in the survey. The states with relatively high numbers of responses (and entries in the directory) were Colorado (33 programs responded), Illinois (23 programs), California (18 programs), and Florida (15 programs). Eleven of the 276 respondents (about 4%) operate in states that do not currently have formal batterer intervention standards in place.

Measures

The Batterer Intervention Program Survey[1] was developed by the authors for this study. The survey consisted of 57 questions assessing program philosophy, structure, clientele, curriculum, policies, operating environment, and evaluation. The survey was completed electronically on a password-protected Internet Web site. Questions were answered by clicking on radio buttons, checking boxes, and typing in text, depending on the nature of the question (open- vs. closed-ended).

Procedures

The survey was posted on an Internet domain page and was password protected so that access to the survey was by invitation and required knowledge of a standard username and password (i.e., programs were informed that these were not unique to specific programs and programs could not be identified by them). Each program in the directory was contacted via telephone and asked to provide an e-mail address where a link to the online survey as well as instructions for participation could be sent. A URL linking them to the survey, the username, and password were e-mailed to all programs that agreed to receive them. Reminder e-mails were sent to all programs 2 weeks after the original e-mail and a second reminder was sent about a month later. Programs were not compensated for participating.

RESULTS

Program Structure

Modality. Aldorondo and Mederos (2002) suggested that male-only, specialized groups operating within a coordinated community response network are considered the most appropriate treatment modality for men who batter. The group approach is popular not only because it is more cost-effective but also because it provides an opportunity for men to mentor each other, share experiences, and challenge maladaptive attitudes and beliefs in a social context similar to the one from which the behavior is thought to have originated (Adams & Cayouette, 2002; Sinclair, 2002). Most states' standards (98%) reflect that a group modality is preferred, with very few exceptions granted, usually under conditions where a group is not possible (Maiuro & Eberle, 2008). In general, early attempts to treat batterers individually or in couples therapy were thought to be ineffective (Gelles, 2001; Mederos, 2002) and possibly dangerous. The standards in many states prohibit the use of couples therapy as the primary approach to batterer intervention (Maiuro & Eberle, 2008), therefore, when used, it is more likely in conjunction with group or following group completion. The survey results confirm the popularity of the group approach.

The vast majority of programs (82%) reported that more than 95% of the offenders they serve are treated in a group format. Most programs (81%) reported that their programs utilize an open-ended, group format, meaning that clients may be added and terminated as the group proceeds. Regarding group size, the mean and median reported were 10 (SD = 3.4). Only about 5% of programs reported treating the majority of batterers in their program on an individual basis. A small minority of programs (13%) reported that they offered couples treatment as a form of batterer intervention. However, those programs also reported conducting couples treatment with a very small number of clients (less than 20% of batterers treated by the program).

Philosophy. In the literature, the most popular descriptors of batterer intervention programs are psychoeducational, profeminist, cognitive-behavioral, and the most common specific model is Duluth. As noted previously, these descriptors are not mutually exclusive and in recognition of this, survey respondents were asked to endorse all of the descriptors that applied to their program. The most popular descriptor selected was "psychoeducational," which was endorsed by 59% of the responding programs. More than half of all programs (53%) self-described as Duluth model programs. This is consistent with Bennett and Vincent's (2001) observation regarding programs in Illinois that "half

of the programs (surveyed) say they utilize some variation of the Duluth approach." It is also consistent with Maiuro and Eberle's (2008) nationwide survey of state standards indicating that the majority of standards (95%) endorse a treatment philosophy based on the conceptualization of domestic violence as a form of power and control. Although not explicit in most standards, the centrality of power and control is a primary tenet of the Duluth model. Almost half (49%) endorsed a cognitive-behavioral orientation, and despite the bias against therapeutic approaches, 26% claimed to be therapeutic programs. We also examined the various combinations of descriptors. The most popular combinations were of Duluth, cognitive-behavioral therapy (CBT), and psychoeducational models. Surprisingly, only 19 programs (7%) selected the term profeminist to describe their approach.

Program Length. There have been very few surveys or experimental studies that address the duration of intervention programs. Those that do so have pointed out that BIPs tend to vary greatly from state to state in terms of number of sessions (Gondolf, 1990; Maiuro, Haggar, Lin, & Olson, 2001; Rosenbaum, Gearan, & Ondovic, 2001). Program length is often arbitrarily stipulated by state standards, and the question has been raised whether more sessions produce better outcomes (Rosenbaum et al., 2001). Although results are inconclusive, there is empirical evidence that shorter programs have higher completion rates and lower recidivism rates. (Edleson & Syers, 1990, 1991; Pirog-Good & Stets, 1986). There are, however, no studies examining 52-week programs or comparing 52-week programs to those of shorter duration. Economic considerations related to program length are also important. Longer programs are more expensive and may differentially penalize poorer participants.

Respondents were asked about the length of their programs, both in terms of number of sessions and length of each session. The average number of program sessions was 31 and the average length per session was 96 minutes. It is important to note that the mean number of sessions may be somewhat elevated by the overrepresentation of states whose standards require a relatively higher number of sessions (e.g., California requires 52 sessions). The median and the modal number of sessions were both 26, which may be more typical of program length nationwide. The number of sessions ranged from 6 to 90, which mirrors previous reports that program length varies dramatically (Gondolf, 1990; Maiuro et al., 2001; Rosenbaum et al., 2001). The length of individual sessions also showed variation (range 60–120 minutes) with the majority of programs (56%) reporting sessions of 90 minutes each. Hence, the typical length of batterer intervention programs was 40 total hours.

Facilitator Characteristics

The training and credentials of group facilitators is a relative unknown. When BIPs first began to expand in the 1980s, it was not uncommon to find programs with facilitators having less than a bachelor's degree and/or leaders lacking specialized training in batterer intervention (Geffner & Rosenbaum, 2001; Mederos, 2002). Program curricula differ in their facilitator education requirements. For example, there are programs that emphasize a peer re-education model in which senior participants take on a leadership role (e.g., the Manalive program), whereas other programs (e.g., CBT programs) require a trained therapist to lead the program. There has been an increase in state standards requiring a minimum level of education for group facilitators, with 40% now requiring at least a bachelor's degree in a human services field along with additional training in domestic violence (Maiuro & Eberle, 2008).

We found great variability regarding the education and training of group leaders, even within the same program. Most programs (71%) reported having at least one staff member with a master's degree and 42% of programs reported having at least one staff member with a master's in social work. Just over one-quarter of the programs (27%) reported having at least one staff member with a Ph.D. or Psy.D., whereas only 2% reported having at least one staff member with an M.D. In addition to education level, program leaders were asked whether any of their staff members were rehabilitated (reformed) batterers. Thirteen percent of programs reported that they had at least one staff member who was a reformed batterer. In Washington state, ex-batterers are ineligible as group facilitators, and in all other states they must be violence-free for a fixed time period (at least 1 year) before they are allowed to lead groups.

Programs also differ in terms of how many facilitators run each group and whether there are specific facilitator requirements. For example, the EMERGE program encourages staffing groups with male–female coleaders based on the belief that attitudes toward women are more likely to surface in the presence of a woman. Further, an egalitarian model of male–female interaction can be modeled by group leaders (Adams & Cayouette, 2002). We found all combinations of coleadership to be represented among programs, with the male/female coleader team being the most popular. One-third of all programs reported that the majority of their groups are co-led by a male/female team. One-fifth of programs reported that the majority of their groups are led by a single male leader, and 15% reported that the majority of their groups are led by a single female leader. About 8% reported that the majority of their groups are led by either two females or two males.

Curricular Issues

The specific intervention strategies employed by BIPs have been adequately described elsewhere, and it was not a purpose of this survey to examine them. However, three general curriculum topics were of interest. In recent years, much attention has been paid to the fact that batterers are a heterogeneous population and that IPV is multidetermined. Consequently, it has been repeatedly argued that in terms of intervention programs, one size probably does not fit all and a prescriptive approach matching the intervention to batterer subtype may be necessary. Saunders (1996) provided some empirical support for this idea demonstrating that antisocial batterers responded better to a cognitive-behavioral approach, whereas batterers with dependent personalities did better in process-psychodynamic groups. We were interested in whether the belief that one size doesn't fit all translated into specialized programs in the field. Programs were asked whether they followed a uniform approach with all batterers or whether they provided different types of treatment based on some characteristic or subtyping of the client. Almost all programs (90%) reported that they followed a "one size fits all" approach to intervention, and only 10% offered any type of differential treatment to program participants.

The second curricular topic concerned the incorporation of alcohol and/or substance abuse treatment. The relationship between IPV and both alcohol and substance abuse is widely accepted (Bushman & Cooper, 1990; Gondolf, 1999); consequently, there is support for the inclusion of alcohol/substance abuse treatment modules in batterers intervention (Stuart, 2005). Despite this, just over half of programs (55%) reported including an alcohol/substance abuse module in their protocols. Irrespective of whether a program includes an alcohol/substance abuse module, across all programs approximately one-third of participants are referred out for alcohol/substance abuse treatment.

In contrast, anger management as a treatment for IPV is more controversial. Concerns have been raised about whether anger management training is appropriate for inclusion in BIPs (Bancroft & Silverman, 2002; Gondolf & Russell, 1986). It has been argued that battering is about power and control, not anger. In fact, in their standards, several states cautioned that anger and stress management were only appropriate with the caveat that abuse is a controlled behavior, not an anger response. Several states (e.g., West Virginia) prohibit anger management on the basis that it could be used to excuse abuse, or out of fear that anger management programs without specific IPV content would be substituted for batterer intervention programs by the courts. Consequently, we were surprised that a large number of programs (76%) reported including an anger management module in their protocols.

Confidentiality

Confidentiality. In the psychotherapy domain, the ability of the therapist to protect the confidentiality of disclosures by the client is seen as essential to the effectiveness of treatment. Confidentiality has been called the cornerstone of psychotherapy and the right of clients to have their privacy protected has been recognized by all 50 states. Yet, the courts have also recognized that this essential right ends where public peril begins (Tarasoff v. Regents of California, 1976) and thus, confidentiality may be limited. In the mental health professions, confidentiality may be breached when a client threatens harm to another person or poses a threat to him/herself. In the batterer intervention domain, great pains have been taken to disassociate intervention from psychotherapy, to identify the victim as the client, and to make victim safety the priority. Thus, the question of whether to protect the confidentiality of disclosures made in the course of batterer intervention is a contentious one. In this survey, almost one-third of programs (31%) reported that they followed the ethical guidelines of a specific profession (i.e., APA, ACA, or NASW), yet only 20% of programs agreed that they treat all information as confidential unless a threat was made against someone. Twenty-eight percent of programs reported that they shared information with victims, courts, and/or probation officers. However, only 1% of reporting programs indicated that they did not protect confidentiality at all. It could be surmised that, despite general agreement regarding the pre-eminence of victim safety, practicing batterer interventionists—like their colleagues in the mental health professions—recognize that effective treatment may require some protection of confidentiality, albeit not as much as in a typical counseling relationship.

Contact With Victims

The first intervention programs established the practice of having contact with victims in order to facilitate safety planning, referrals for services, and sharing information related to the batterer's violent behaviors (Mederos, 2002). The extent to which programs contact victims varies, but most programs (75%) contact victims at least once over the course of the batterer's participation in the program. Specifically, 36% of programs reported that they contact victims twice—once when the offender begins the program and once when the offender completes the program; 22% of programs reported that they contact the victims only once at the beginning of the program. Seventeen percent of programs reported that they only contact victims if a threat has been made; 15% reported contacting victims every few weeks; 2% of programs reported contacting victims once per week; and only 8% of programs reported that they never contacted victims. It should

be noted that many state standards prescribe victim contact. In light of this, we were surprised at the small number of programs reporting that they make frequent contact with victims.

Program Logistics

We began the article with some estimates of the magnitude of the problem of IPV and the fact that batterer intervention is apparently the treatment of choice, at least from the judicial perspective. To date, no national figures on the number of IPV offenders served in BIPs are available; therefore, we were interested in the number of batterers treated by these programs. Respondents were asked about the number of clients referred to their program per year as well as how many clients began and completed their program per year. Programs varied widely in terms of numbers of clients, with responses ranging from 1 to 1,600 client referrals per year. The average number of perpetrators referred to programs per year is 168 with a median of 100. Many programs report a substantial dropout rate between referral and the start of intervention. The responses for how many perpetrators actually began programs per year ranged from 1 to 1,100, with the average number of clients attending an intake or at least one session being 131; the median was 95. The number of perpetrators completing programs per year ranged from 1 to 800, with the average number being 101; the median was 75. The rather large differences between means and medians for all three of these figures may be due to sizeable outliers, thus the medians may be the more meaningful statistic.

Whether women might be batterers is one of the more controversial issues in the IPV field. Although it is generally acknowledged that female-to-male aggression may be as common as the male-to-female configuration (Straus, 2004), whether this constitutes battering is another matter, and because female aggression typically lacks the ability to evoke fear and compliance in the male, it typically does not. Nevertheless, as a result of mandatory and proarrest arrest policies, women are increasingly being charged with and prosecuted for IPV. Of interest to the present study is whether they are also being treated by BIPs. Overwhelmingly, BIPs treat male perpetrators with a ratio of males to females of approximately 9:1. However, when asked whether they provide programs for both male and female batterers, almost three-quarters (74%) reported that they did. It was clear that the vast majority of programs (96%) do not treat males and females in the same groups.

Research has informed us that aggression is as common in same-sex couples as it is among heterosexuals (West, 1998). Although same-sex couples may be less likely to call the police, and perhaps less likely to be taken seriously by the police and the courts (Pattavina, Hirschel, Buzawa, Faggiani, & Bentley, 2007; Younglove, Kerr, & Vitello, 2002), the availability of intervention services for homosexuals was assessed. The survey results indicated that more than three-quarters (78%) of programs reported that they would provide services to homosexual batterers; however, homosexual batterers comprised a very small percentage of their clientele (the median for these programs was 1% of participants).

If both males and females can be aggressors, then both can also be victims. Of interest was how many BIPs also offered services to victims of either sex. Not surprisingly, programs were more likely to offer services to female victims, and almost half (48%) did so. But, 38% of programs also reported that they offered treatment for male victims of domestic violence. This should not be interpreted to mean that more than half of the programs are nonresponsive to the needs of victims. It is possible and, in fact, likely that many

BIPs refer victims (most likely female ones) to shelters and other service providers, which are independent of the BIP. In fact, most state standards require BIPs to relate to the local shelters as part of a coordinated community response, whereas some states (e.g., Illinois) do not permit the same agency to provide services to both perpetrators and victims.

Relationship to the Courts

A major innovation of the Duluth model was the coordination of all of the community agents and agencies involved in the response to IPV, such as the police, shelters, and the courts. There are a number of ways that the legal environment in which a program operates may be important. Perhaps the most important aspect of the relationship between BIPs and the courts is the referral process. Confirming this, in response to the question regarding what percentage of participants were court mandated into the program, the median response was 96%; the mean was 89%.

Regarding relationships between BIPs and the court systems, the reports from programs were positive, with most programs (87%) reporting an "excellent" (55%) or "very good" (32%) relationship with their local court system and probation department. Eight percent of programs reported having a "good" relationship and 5% reported having a "mixed" relationship; less than 1% reported having "no relationship" or a "poor" relationship with the court system and/or probation department in their area. Concerning how well programs thought their local court system dealt with IPV cases, only 13% thought they did an excellent job. An additional 68% felt that the courts did a good job but that there was room for improvement. On the negative side, 17% reported that their court system needed substantial improvement.

An important function of the judicial system is to enforce treatment completion and to protect victims by promptly dealing with noncompleters. Most BIPs (92%) reported that they terminate batterers for excessive absences. Some programs (e.g., those in Illinois) are required by their state protocols to terminate batterers who reaggress or who are rearrested for a domestic offense. The assumption of most programs is that this is protective of victims in that termination from the program will result in rearrest and incarceration. We evaluated the accuracy of this assumption.

Programs were asked about the court response to batterers who were prematurely terminated from the BIP. Sixty-three percent of programs reported that most offenders are given at least a second chance to complete the same or similar program; 19% reported that these offenders are rearrested and sent to jail; and 17% reported that they did not know exactly what happened to these offenders. Considering the importance of victim safety and the emphasis on a coordinated community response, it is surprising that so many programs do not know what happens to offenders who are prematurely terminated from their programs. It should be of some concern that only a fifth are rearrested and jailed. Out of concern for victim safety, BIPs and state standards as well might have to reconsider the advisability of terminating batterers for either poor attendance or reoffending.

Program Support

Although IPV is thought to cut across socioeconomic strata, the poor and disadvantaged are most likely to be prosecuted and required to attend BIPs. Because, from the court perspective, this represents a punishment following a conviction, paying for the group is considered part of the negative consequences, tantamount to a fine. Further, because the dollars earmarked for IPV are limited, shelters and BIPs are competing for the same

monies. We were interested in how BIPs are supported. According to this survey, more than half of all programs (54%) were funded exclusively by batterer payments for services and 87% of programs relied, at least in part, on fees paid by batterers. Slightly less than half of all programs (46%) reported receiving at least some of their funding from another source, such as the government (federal, state, or local), private donations, and/or foundations, such as United Way and Catholic Charities. Because of the low socioeconomic circumstances of this population, many programs must slide fee scales, and despite this, collection rates may still be low. It is understandable, therefore, why so many programs fail to thrive.

Having operated a BIP for 22 years, the second author has experienced firsthand the problems confronting BIPs, many of which can be attributed to inadequate funding streams. We have already discussed the failure of BIPs to offer specialized services such as alcohol and substance abuse treatment or specific programs tailored to the needs of different batterer subtypes (i.e., the one size fits all problem). Contacting victims is also labor intensive. Many programs lack either the client flow or the finances to provide these services. Perhaps even more problematic is the failure of programs to provide services in languages other than English. Only a third of programs reported that they offer groups in a language other than English. All of the programs that do offer groups in another language reported offering them in Spanish. About 2% of programs also offer groups in other languages, including Russian, Hmong, French, and Korean, and less than 1% of programs reported offering groups in American Sign Language. We are concerned that non-English speakers may be attending programs conducted in languages they cannot understand and yet will be considered to have completed. This cannot be consistent with concerns about victim safety. However, given the financial constraints, we cannot expect programs to offer services in different languages without external support.

Outcome

Mandating attendance to a BIP is only a reasonable judicial option if it can be demonstrated that as a result batterers are less violent and victims are safer. Of concern is the likely assumption of victims that the courts would not send batterers to programs unless those programs worked; an assumption that might increase the likelihood of women remaining in, or returning to, abusive relationships. Although the empirical evidence provides weak support for the efficacy of BIPs (Babcock, Green, & Robey, 2004), only a small number of treatment models (primarily Duluth) and lengths (generally fewer than 30 weeks) have been subjected to outcome evaluation. In many states, the BIP certification standards stipulate that the programs collect outcome data; however, it is not clear if, or how, these data are utilized. In Massachusetts, for example, the standards require programs to "establish a system for collecting statistical data" that includes successful treatment and unsuccessful discharge. A recent inquiry to the Massachusetts Department of Public Health Division of Violence Prevention revealed that it has only recently (after more than 16 years of having standards) begun collecting and organizing data from certified programs. More troubling is the fact that it is only presenting utilization and demographic data, not outcome data, (R. Haynor, personal communication, March 28, 2008).

We asked program leaders whether they collected any outcome data. About 28% of programs reported that they are required by state regulations to conduct empirical research evaluating the outcome of their program. However, more than half of all responding programs (56%) reported actually collecting outcome data. Of the programs

collecting data, 44% collected outcome data at the conclusion of group, which might not allow sufficient time for recidivism and inflate success rates. Almost one-fifth of programs collected outcome data after 6 months, 15% after 1 year, and 8% after more than 1 year. Almost a quarter of the programs collected data only once, be that at the conclusion of group or some time afterward. Although our survey did ask programs to report on their success and recidivism rates, we are not reporting those figures because they are elevated in comparison to more methodologically sound outcome evaluations and meta-analyses.

DISCUSSION

We conducted this survey because batterer intervention programs have become the primary societal weapon in the effort to eliminate intimate partner violence and protect victims, yet we know almost nothing about the actual programs providing these services. In fact, after years of work on this project, we still do not know exactly how many programs are currently operating in the United States. We have learned that whatever that figure is, it will only be accurate for a brief time, as evidenced by the fact that almost one-third of programs in the initial database were no longer in existence when we tried to contact them. We also learned that programs are wary of research about their programs. This is the largest known survey of programs in the field, yet we were only able to get responses from 276 programs, despite numerous follow-up calls and reminder e-mails.

This latter point also highlights the most significant limitation of this study, the low response rate. Regardless of how it is calculated (14.7% of programs contacted or 19.7% of programs agreeing to receive the e-mailed information), the participation rate prohibits us from claiming a representative sample. The anonymity of the sample prevents us from making any comparisons between responders and nonresponders, but it also provides us with greater confidence in the validity of the information provided. Replication with a larger, more representative sample is certainly warranted.

Nevertheless, our results highlight some important issues. They confirm that open-ended, psychoeducational, gender-specific groups are the most popular intervention format. The typical group is run by a male–female coleader team and is approximately 40 hours in length. Mental health professionals are well represented among program staff, but reformed batterers are not. Alcohol/substance abuse and anger management modules are frequently included in batterer intervention programs. Most programs will treat perpetrators of either sex, but the vast majority of program participants are male. Most programs are willing to treat homosexual batterers but rarely do so. Few programs offer couples counseling, but even those that do treat very few batterers in a couple counseling format.

Almost all programs reported a good to excellent relationship with the legal systems in their areas, which is not surprising given the symbiotic relationship between BIPs and the courts. Without court mandates, few batterers would participate in treatment, and without BIPs, the courts would have few options for sentencing batterers. On the negative side, there appears to be very little institutional support for BIPs, with almost all programs depending on fees charged to batterers for at least some of their funding, and with the majority relying exclusively on fees paid by batterers. Given the low socioeconomic status (SES) and economic instability of this population, the failure of so many BIPs to thrive is understandable.

Also of concern is the fact that despite the consensus in the field that batterers are a heterogeneous group and that programs matched to batterer subtypes and stages of readiness to change are necessary, they are almost nonexistent in actual practice. One size had better fit all. Perhaps more problematic is the fact that programs are largely conducted in English only. When programs are offered in languages other than English, the other language is almost always Spanish. In fairness, offering different types of groups, be they prescriptively matched to batterer characteristics or conducted in a language other than English, requires adequate funding, and that is not a reality for most BIPs. If society is going to rely so heavily on batterer intervention programs as a response to intimate partner violence, it will have to provide better support to the programs providing these services.

NOTE

1. For copies of the Batterer Intervention Program Survey, please contact the first author: bprice@niu.edu

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