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Integrating the Principles of Effective Intervention into Batterer Intervention Programming: The Case for Moving Toward More Evidence-Based Programming

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**Integrating the Principles of Effective Intervention into
Batterer Intervention Programming:
The Case for Moving towards more Evidence-Based Programming**

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Abstract

The majority of batterer intervention program evaluations have indicated they are marginally effective in reducing domestic violence recidivism. Meanwhile, correctional programs used to treat a variety of offenders (e.g., substance users, violent offenders, and so forth) that adhere to the “principles of effective intervention” have reported significant reductions in recidivism. This paper introduces the principles of effective intervention – the principles on which evidence-based practices in correctional rehabilitation are based - and identifies the degree to which they are currently integrated into batterer intervention programs. The case is made that batterer programs could be more effective if they incorporate the principles of effective intervention. Recommendations for further integration of the principles into batterer intervention programs are also provided.

Keywords: batterer intervention programs, domestic violence, principles of effective intervention, correctional rehabilitation, evidence-based practices

Introduction

Batterer intervention programs (BIPs) vary in their theoretical approaches, styles, and modes of service. However, a primary focus of all BIPs is to reduce domestic violence recidivism; yet, evaluations of BIPs have shown mixed evidence in reducing domestic violence (DV), with many programs having little to no effect on recidivism (Babcock, Green, & Robie, 2004; Feder & Wilson, 2005; Gondolf, 2004). For example, findings from a review of over 40 BIP evaluations indicated that nearly 50% of batterers recidivated after a 4-year follow-up period (Gondolf, 2004). Clearly, there is sufficient room for improvement. This is especially true when compared to other correctional interventions provided to general offenders, where reductions in recidivism have been as high as 80% to 90% (Andrews, Zinger, et al., 1990; Antonowicz & Ross, 1994; Dowden & Andrews, 2000). Why are these programs so much more effective at curbing offender behavior than current BIPs? We contend that these “effective” correctional programming services adhere more strictly to the “Principles of Effective Intervention,” which primarily lay the foundation for evidence-based practices (EBPs) used with correctional¹ populations today (Cullen & Gendreau, 2000). We suggest that one route to improving current BIPs is to incorporate these principles which are used in corrections, and apply them to batterer intervention programming. Indeed, some scholars have already noted the need for BIPs to incorporate evidence-based principles found in correctional interventions (Scott, 2004), yet to date, this has not systematically been done. Therefore, the purpose of this manuscript is two-fold: First, we will outline and review the Principles of Effective Intervention (PEI) as they are used in correctional evidence-based practices and we will describe the degree to which BIPs are comporting to these principles. Second, we provide recommendations for how BIPs can better

integrate these principles in order to potentially become more effective at reducing batterer recidivism, and in doing so, also become more “evidence-based.”

Domestic Violence and The Creation of Batterer Intervention Programs

DV is a persistent social problem within the United States (Catalano, 2013). On average, over 800,000 violent victimizations are experienced by women at the hands of their male intimate partners each year (Catalano, 2013),² with the majority being victimized by the same offender on more than one occasion (Catalano, 2012). Many of these violent relationships can be deadly - in 2010, over 39 percent of female homicides were committed by an intimate partner (Catalano, 2013). Moreover, these numbers do not fully represent the amount of DV occurring within the United States, as DV incidents are vastly underreported (Catalano, 2004).

DV emerged from behind the cloak of family secrecy in the early 1970s, when women’s movement advocates began opening shelters for battered women to seek refuge (Babcock, Canady, Graham, & Schart, 2007). Shortly thereafter, shelter workers and advocates realized that many victims returned to their abusive partners for a variety of reasons (e.g., financial security, children, fear of increased violence; Davis & Taylor, 1999; Feder & Wilson, 2005; McGee, 2005). In response, feminist advocates formed the first BIPs, which placed heavy emphasis on changing a batterer’s patriarchal views and behaviors (Babcock et al., 2007; Gondolf, 2002). The intent of the BIPs was to increase victim safety while reducing recidivism by altering batterers’ attitudes and behavior. Initially, few batterers attended BIPs because admittance was voluntary. In the mid-1980s, however, an abundance of DV offenders began entering the criminal justice system due to new pro-arrest statutes for DV-related incidents as mandated by several states. Because the influx of arrested batterers placed strain on the already overcrowded correctional institutions and because many of the batterers qualified for probation (which would immediately

place them back into contact with the victim), the criminal justice system began to sentence batterers to BIPs as an alternative to probation and to potentially restrain their abusive actions towards their partners.³ These BIPs were also attractive to many victims, as they enabled batterers to be sanctioned, yet still meet their financial responsibilities to their families (Davis & Taylor, 1999; Gondolf, 2002).

The feminist psychoeducational approach remains the dominant approach of BIPs today (Babcock et al., 2007; Pence & Paymar, 1993); however, other approaches have emerged, such as psychodynamic and cognitive-behavioral approaches (Gondolf, 2002). And while there is variation in the approaches and techniques that BIPs use, the typical BIP requires batterers to attend weekly group sessions for three to twelve months where they interact with counselors and work through required curriculum with the primary goals of reducing recidivism and increasing victim safety. Evaluations of batterer program effectiveness have shown mixed support, though, with the majority revealing little to no evidence in recidivism reduction (Babcock et al., 2004; Gondolf, 2004). For example, Babcock and colleagues (2004) concluded that the BIPs in their meta-analytic review were only marginally effective at reducing recidivism, with effect sizes hovering in the “small” range. This is a particularly salient issue, given both the high prevalence of DV, and repeated instances of DV, occurring within the United States (Catalano, 2012, 2013).

Domestic Violence Offenders and General Offenders

While some scholars have assumed that DV offenders are qualitatively different than other, more general types of offenders (Piquero, Brame, Fagan, & Moffitt, 2006; Piquero, Theobald, & Farrington, 2014), there is evidence that DV offenders are similar to general offenders in many respects. Consequently, it is possible that interventions used to treat general offenders may also be applied to DV offenders.

Scholars have long debated whether criminal offenders are generalists or specialists in the crimes they commit. Researchers have extended this line of inquiry to include whether DV batterers are unique offenders or “general” offenders who at times commit DV offenses (Piquero et al., 2006; Piquero et al., 2014; Richards, Jennings, Tomsich, & Gover, 2013). Though the number of studies that examine this question is limited, research has identified several similarities between offenders who commit DV offenses and offenders who commit other offenses, calling into question whether offenders truly “specialize” in their offenses. For example, Piquero and colleagues (2006) found that very few of the DV offenders in their study specialized strictly in DV, since most had prior nonviolent criminal histories; they concluded that such a range of criminality was indicative of general offending rather than specialization. Richards and associates (2013) also determined that DV specialization was an infrequent occurrence in the long term arrest patterns of DV offenders. Their findings indicated that trajectories for DV-specific rearrests and non-DV rearrests were very similar and the predictors (i.e., prior DV arrest, prior drug/alcohol crimes, age) of DV arrests were the same as those for non-DV arrests. Findings from another study of offender trajectories revealed that there was significant similarity between men who had been convicted of criminal violence and men who had been convicted of DV (Piquero et al., 2014). Furthermore, evidence has indicated that long term predictors of intimate partner violence perpetration, victimization, and recidivism parallel long term predictors of general offending (Lussier, Farrington, & Moffitt, 2009). Therefore, programming practices that work with general offenders may also apply to DV offenders.

Evidence Based Practices: A Brief Introduction

Within correctional research, rehabilitation interventions are considered effective when the interventions are successful at reducing recidivism.⁴ Researchers have examined numerous

institutional- and community-based correctional programs used with various offender populations (e.g., violent and nonviolent, probationers, parolees, substance abusers) in a quest to determine what differentiates ineffective and effective correctional programs (Andrews, Bonta, & Hoge, 1990; Andrews, Zinger, et al., 1990; Gendreau, 1996). Derived from sources including narrative and meta-analytic reviews and clinical experience, researchers have identified the main aspects of treatment that make correctional programs effective, and have shown that adhering to these certain “principles” in treatment is associated with the greatest reductions in recidivism among offenders (Gendreau, 1996). These principles are known as the “Principles of Effective Intervention” (PEI) and include risk, need, responsivity, treatment, and fidelity. In one of the first studies to examine the effectiveness of correctional programs which adhered to the PEI, Andrews and colleagues (1990) reported reductions in recidivism averaging over 50% among these programs. Subsequent reviews of diverse correctional programs (e.g., with sex offenders, juveniles, substance abusers) support Andrews and his colleagues’ findings in that correctional programs which incorporated the PEI showed significant reductions in recidivism, above the reductions in recidivism generated by non-PEI adhering programs (Antonowicz & Ross, 1994; Dowden & Andrews, 1999, 2000; Lipsey, 1995; MacKenzie, 2006; Smith, Gendreau, & Swartz, 2009). In fact, in a systematic review of correctional programs, Lipsey and Cullen (2007) found recidivism reductions ranging from roughly 20 to 40%. Over time, the successes of the PEI have become so salient in the correctional literature that they are identified among the “best practices” and synonymous with EBPs in correctional interventions (MacKenzie, 2006).

The Risk Principle

Two components comprise the risk principle. First, offenders should be assessed and subsequently classified into low-, medium-, and high-risk groups based on their likelihood to re-

offend (Andrews, Bonta, et al., 1990). Risk factors for criminal behavior can be static (i.e., unchangeable factors, such as criminal history and age at first arrest) or dynamic (i.e., changeable factors, such as attitudes or substance use) (Smith et al., 2009), and should be used to classify offenders into these groups. Second, an offender's risk level should match treatment intensity, where high-risk offenders participate in more intensive treatment while low-risk offenders receive minimal or no treatment (Andrews, Bonta, et al., 1990).

Numerous studies have found support for the risk principle when examined among correctional populations (e.g., Lowenkamp & Latessa, 2005), with several meta-analytic reviews indicating that treating higher-risk offenders with more intense treatment yields higher reductions in recidivism than treatments targeting low-risk offenders (Andrews & Dowden, 1999, 2006; Lowenkamp, Latessa, & Holsinger, 2006). Findings from several studies have also indicated that more extensive services delivered to low-risk offenders may actually do more harm than good (Andrews, Bonta, et al., 1990; Bonta & Andrews, 2007; Lowenkamp & Latessa, 2005). This is because exposure to intensive programming may create the opportunity for low-risk offenders to associate with high-risk offenders who may display antisocial behaviors and criminal attitudes, and time spent in intensive treatment may break the very social bonds that keep these offenders low-risk (e.g., strain prosocial relationships, miss work) (Van Voorhis & Salisbury, 2014). Thus, providing intensive services to low-risk offenders may actually increase their recidivism. In fact, Bonta and colleagues (2000) reported that low-risk offenders who received intensive treatment services had a recidivism rate of 32.3% whereas untreated low-risk offenders had a recidivism rate of 14.5%.

The Need Principle

The needs of an offender are dynamic (changeable with treatment) and are divided into two types: non-criminogenic and criminogenic. Non-criminogenic needs (e.g., low self-esteem, lower economic origins, poor physical condition) are only loosely related to recidivism (Andrews & Bonta, 2010). Criminogenic needs are risk factors that are more strongly associated with reoffending among offenders (e.g., antisocial attitudes) (Andrews & Bonta, 2010; Andrews, Bonta, et al., 1990). The need principle asserts that treatment aimed at reducing recidivism should place emphasis on changing offenders' criminogenic needs as opposed to non-criminogenic needs and/or static factors (Bonta & Andrews, 2007). Seven of the eight most salient predictors of criminal behavior (also known as the "central eight") are criminogenic needs, which include antisocial personality patterns, pro-criminal attitudes, social supports for crime, substance abuse, poor family/marital relationships, poor school/work performance, and low levels of prosocial recreational activities (Andrews & Bonta, 2010; Bonta & Andrews, 2007). The central eight factors have been identified as the strongest predictors of recidivism and criminal behavior, thus, targeting these factors in correctional programming will likely yield greater recidivism reductions (Andrews & Bonta, 2010).

Evidence supports the need principle in correctional programming (Andrews & Dowden, 1999; Andrews, Zinger, et al., 1990; Lowenkamp, Pealer, Smith, & Latessa, 2006). Several meta-analyses have found strong reductions in recidivism for programs targeting criminogenic needs as opposed to non-criminogenic needs (Gendreau, 1996; Smith et al., 2009). Additionally, the number of criminogenic needs targeted by a program has also been linked to recidivism reduction. French and Gendreau (2006) found that compared to programs which incorporate zero changes to criminogenic needs, programs that targeted three to eight criminogenic needs had greater reductions in recidivism nearly 80% of the time, and saw better reductions in recidivism

66% of the time when compared to programs that focused on changing one to two criminogenic needs.

The Responsivity Principle

The responsivity principle states that the style and modes of treatment service should match an offender's ability and learning style (Andrews & Bonta, 2010; Andrews, Bonta, et al., 1990). The responsivity principle encompasses two parts, one of generality and one of specificity (Andrews, Bonta, et al., 1990). General responsivity relates to how offenders respond to treatment intervention overall, wherein offenders tend to perform better when working with collaborative and respectful staff and when they are enrolled in a treatment program that utilizes cognitive social learning strategies (Bonta & Andrews, 2007). Specific responsivity refers to how individual offender characteristics interact with treatment intervention styles and modes, as these characteristics can influence an offender's ability to promote or obstruct treatment (Andrews & Bonta, 2010; Bonta & Andrews, 2007; Smith et al., 2009). Specific responsivity factors comprise a wide range of characteristics including (but not limited to) age, sex, race, ethnicity, intelligence, cognitive maturity, motivation, personality, and anxiety, as well as treatment delivery modes (e.g., confrontational styles or group interventions) (Andrews & Bonta, 2010; Bonta, 1995; Van Voorhis & Salisbury, 2014). Essentially, the responsivity principle emphasizes that offenders are not homogenous and that individual offender's characteristics may either impede or assist his achievements within a rehabilitative program.

Empirical evidence has endorsed and validated the importance of the responsivity principle in effective correctional programming (Andrews, Bonta, et al., 1990; Bonta, 1995), although the responsivity principle has garnered less attention than other principles (Hubbard & Pealer, 2009; Van Voorhis, 1997). Studies have examined program effectiveness and some

specific responsivity factors such as intelligence (Hubbard, 2007; Hubbard & Pealer, 2009; Ross & Fabiano, 1985; Van Voorhis, Spruance, Ritchey, Listwan, & Seabrook, 2004), gender (Hubbard, 2007), personality (Grant, 1965), self-esteem (Hubbard, 2007; Hubbard & Pealer, 2009), sexual abuse history (Hubbard, 2007; Hubbard & Pealer, 2009), and depression (Hubbard, 2007; Hubbard & Pealer, 2009). For example, Van Voorhis and colleagues (2004) examined the effectiveness of a cognitive skills program that focused on responsivity factors such as emotional management, social skills, problem solving, and critical reasoning. They reported that participants in the cognitive skills program had significantly lower recidivism rates and significantly longer times to failure when compared to non-participants (Van Voorhis et al., 2004). Responsivity factors such as age, race, and personality type have also been found to moderate the relationship between cognitive-behavioral treatment and recidivism (Spiropoulos, Salisbury, & Van Voorhis, 2014). Various studies have also demonstrated that responsivity factors may act as barriers to treatment success, wherein failure to account for these factors during treatment may result in the decay of program effectiveness (Andrews & Bonta, 2010; Bonta, 1995; Gendreau, 1996; Van Voorhis & Salisbury, 2014). For instance, while Hubbard and Pealer (2009) discovered that none of the individual factors they examined altered program effectiveness, their findings did indicate that offenders who had a multiplicity of key responsivity factors (e.g., low self-esteem and low intelligence) were less likely to succeed in the program; based on this, they suggest that offenders with several responsivity factors may be at a disadvantage for succeeding in treatment.

The Treatment Principle

The treatment principle follows two guiding elements to elicit behavioral change among offenders (Bonta & Andrews, 2007). First, program staff should be respectful, firm-but-fair, and

well-trained when working with offenders (Andrews, Bonta, et al., 1990; Bonta & Andrews, 2007). Second, treatment services should employ cognitive social learning strategies that incorporate modeling, reinforcement, skill building, cognitive restructuring, problem solving, and role-playing (Andrews & Bonta, 2010; Bonta & Andrews, 2007). Behavioral and social learning approaches utilize a wide variety of strategies, such as using modeling to show offenders how to resolve issues without violence. Additionally, 40-70% of the offender's time spent in the program should be dedicated to acute treatment services, and the duration of a program should be within a three to nine month time frame (Gendreau, 1996).

Support for the treatment principle has been widely recognized within correctional rehabilitation programming (Van Voorhis & Salisbury, 2014). Numerous studies have shown that the incorporation of cognitive-behavioral and social learning techniques into treatment services for offenders results in recidivism reduction (Antonowicz & Ross, 1994; Losel, 1995; MacKenzie, 2000; Smith et al., 2009). For example, Smith and colleagues (2009) found that over 70% of meta-analyses they examined reported at least a 15% reduction in recidivism for cognitive-behavioral interventions, while 88% of non-behavioral interventions failed to reach this threshold. Cognitive-behavioral treatment has also been shown to reduce recidivism among various offender populations, such as offenders within the community (Lowenkamp, Pealer, et al., 2006), juveniles (Dowden & Andrews, 1999; Izzo & Ross, 1990), adults (Lipsey, Chapman, & Landenberger, 2001), males and females (Andrews & Dowden, 1999; Antonowicz & Ross, 1994), substance abuse users (Miller & Hester, 1995; Taxman, 2000), and violent offenders (Dowden & Andrews, 2000). Not only have cognitive-behavioral therapies been found to be effective in correctional intervention, but also across a wide range of psychiatric disorders (i.e.,

depression, PTSD, anger) with various outcomes, including sexual offending, aggression, and anger (Butler, Chapman, Forman, & Beck, 2006).

The Fidelity Principle

The fidelity principle, sometimes referred to as program integrity (e.g., Lowenkamp et al., 2010) or therapeutic integrity (e.g., Smith et al., 2009), focuses on how treatment services are delivered and evaluated.⁵ First, the fidelity principle calls for treatment staff to be qualified, properly trained, and monitored (Andrews, 2006). Second, all aspects of the treatment services should undergo evaluation and assessment to ensure the overall quality of the program and that it is implemented as designed (Andrews, 2006; Latessa & Holsinger, 1998).

Adhering to the fidelity principle is important for treatment success (Latessa, Brusman Lovins, Smith, & Makarios, 2010; Latessa & Holsinger, 1998; Lowenkamp, Flores, Holsinger, Makarios, & Latessa, 2010; Lowenkamp, Makarios, Latessa, Lemke, & Smith, 2010). Evidence from multiple studies has validated the need for programs to have therapeutic integrity, that is, to be administered by skilled and knowledgeable personnel (Aos, 1997; Barnoski, 2004; Lowenkamp, Makarios, et al., 2010). When examining juvenile programs, Aos (1997) revealed that programs conducted by competent therapists were successful in reducing recidivism, whereas recidivism increased when programs were delivered by incompetent therapists (these results were later replicated by Barnoski in 2004). Lowenkamp and colleagues (2010) also reported that juvenile community-based correctional programs scoring “satisfactory” or “very satisfactory” on the staff domain of the Correctional Program Assessment Inventory (CPAI), a tool used to measure how well correctional programs adhere to the PEI, reported more reductions in recidivism than programs scoring in the “unsatisfactory” category on this domain. In an effort to determine what staff characteristics were influential in reducing recidivism, Latessa and

colleagues (2010) reported that reduced recidivism effects were associated with six staff characteristics: maintaining appropriate boundaries so as not to be taken advantage of by offenders, having problem-solving skills, possessing computer skills, having paperwork skills, having a firm-but-fair approach, and being assertive/directive.

Many studies have examined program integrity and its link to effective correctional programming (Holsinger, 1999; Lowenkamp, Flores, et al., 2010; Lowenkamp, Makarios, et al., 2010). The concept of program integrity refers to the degree to which a program's services carried out in practice adhere to its original intentions and theoretical framework (Holsinger, 1999; Lowenkamp, Flores, et al., 2010). Program integrity encompasses several key fidelity variables such as program implementation, assessments and evaluations, and staff and program characteristics. In one of the first studies to examine the relationship between program effectiveness and program integrity, Lowenkamp and colleagues (2006) concluded that program implementation, offender assessment, and evaluation were associated with recidivism reduction. Further, a series of studies by these researchers have indicated that various aspects of program fidelity (e.g., staff characteristics and service orientation, program philosophy, evaluation and feedback, etc., see Lowenkamp, Makarios, et al., 2010) are related to reductions in recidivism among both juvenile and adult offenders housed in the community, with stronger reductions in recidivism among programs that adhere to more components of program integrity. Although research in this area is somewhat in its infancy, initial reports indicate that the fidelity or the quality with which a program is implemented and monitored may have strong impacts on its success in reducing recidivism.

The Principles of Effective Intervention and Batterer Intervention Programs

This section discusses the degree to which BIPs are currently adhering to the PEI. This information is also presented in table format in the Appendix.

The Risk Principle within Current Batter Intervention Programming

Recall that the risk principle states that an offender's risk for reoffending must be equivalent to the level of service he receives (Andrews, Bonta, et al., 1990). To a certain extent, BIPs are currently adhering to the risk principle in part because they use risk assessments and acknowledge that batterers are not homogeneous. First, many BIPs use DV risk assessments to determine which sanction (e.g., incarceration, community release, treatment program) an offender should receive as well as to evaluate whether an offender needs supplementary services or more intensive treatment (Dutton & Kropp, 2000; Gondolf, 2012). Additionally, DV risk assessments, such as the Spousal Assault Risk Assessment (SARA) (Kropp, Hart, Webster, & Eaves, 1994, 1995, 1998) and the Ontario Domestic Assault Risk Assessment (ODARA) (Hilton, Harris, & Rice, 2010; Hilton et al., 2004), have been developed to predict recidivism among batterers (Campbell, 1986, 1995; Hilton et al., 2010; Hilton, Harris, Rice, Houghton, & Eke, 2008; Hilton et al., 2004). These tools often provide manuals, staff training, and guidelines for appropriate use (e.g., Kropp & Hart, 2000), and evaluations have shown support for their ability to predict recidivism among batterers (Hilton et al., 2008; Hilton et al., 2004; Kropp & Hart, 2000). However, Gondolf (2012) examined state standards and guidelines in regards to the utilization of risk assessments within BIPs and revealed that the majority of states required or recommended that offenders be assessed for their risk of recidivism; yet, he concluded that regardless of the outlined standards, there was a general lack of regularity and clarity with how to conduct the assessments, as well as what is to be done once results are determined.

There may also be a variety of types of batterers who attend BIPs (Babcock, Miller, & Siard, 2003; Cavanaugh & Gelles, 2005; Gottman et al., 1995; Holtzworth-Munroe & Stuart, 1994; Johnson, 1995, 2008). Numerous typologies have been identified, however, some of the more widely recognized and recent works are those by Johnson (1995, 2008), Holtzworth-Munroe and Stuart (1994), Gottman and colleagues (1995), Gondolf (1988), and Cavanaugh and Gelles (2005). These batterer typologies differ somewhat according to how the subtypes are identified, but the overarching similarity between them is that each offender is categorized in part by his violence. For instance, Johnson (2008) categorized DV into four distinct types (intimate terrorism, violent resistance, situational couple violence, and mutual violent control) according to the amount of violence that occurred within an intimate partner relationship. Holtzworth-Munroe and Stuart (1994) classified male batterers into three categories (i.e., family only, dysphoric/borderline, violent/antisocial) based on the severity of violence within the intimate relationship, the amount of violence committed by the batterer towards his partner and others, and psychopathology or personality disorders. Gottman and colleagues (1995) divided batterers into two groups (i.e., Type I and II) depending on the batterer's heart rate reactivity, emotionally aggressive behavior, and the violence that occurred outside the confinement of the intimate relationship. Gondolf (1988) developed a typology of batterers (Type I, II, and III) based on violence that occurred inside and outside the intimate partner relationship, and Cavanaugh and Gelles (2005) determined three types of offenders (i.e., low, moderate, and high-risk) by violence frequency and severity, criminal history, and psychopathology levels. Therefore, while some typologies measure certain psychological variables (e.g., personality) while others do not, they all examine the level of violence in the relationship, so the most violent (or high-risk) batterers should be identifiable regardless of the typology used.

Two considerations regarding the risk principle can be drawn from the use of risk assessments and identification of batterer typologies in BIPs. First, while risk assessments are a component of BIPs, they are not being utilized uniformly or to their full potential (i.e., dividing offenders into treatment based on risk level). Second, important differences regarding who attends, completes, and ultimately benefits from BIP treatment may exist between batterer types; however, the majority of BIPs disregard these differences and continue to treat offenders as a monolithic group.

The Need Principle within Current Batter Intervention Programming

Recall that the need principle asserts that treatment services should target criminogenic needs, or those needs most strongly associated with criminal behavior (Andrews & Bonta, 2010). Some components of the need principle can be recognized within current BIPs, such as BIPs' aim to change attitudes, their understanding of the link between substance abuse and DV, and their assessment of some needs during the intake process. First, several BIPs place an emphasis on changing attitudes and beliefs in the treatment process (Buzawa, Buzawa, & Stark, 2012). An illustration of this is seen in feminist psychoeducational programs, where the core of their curriculum is the notion that DV is a result of the patriarchal ideology held by society. Therefore, these programs seek to change the patriarchal views men have of women (Dobash & Dobash, 1979; Pence & Paymar, 1993). However, as previously noted, program evaluations have indicated that they are largely unsuccessful (Babcock et al., 2004; Davis & Taylor, 1999). One plausible explanation for this is that programs are not focusing specifically on antisocial attitudes, which is a major risk factor for criminal behavior, and is also changeable with treatment (i.e., a dynamic criminogenic need).⁶ And as the need principle states, targeting the most salient and

multiple criminogenic needs – those factors most strongly linked to criminal behavior, such as antisocial attitudes - will likely lead to the greatest reductions in recidivism.

Second, BIPs appear to be aware of the comorbidity between DV and substance abuse. That is, BIPs recognize that substance use is a major correlate of DV (DeMaris, Benson, Fox, Hill, & Van Wyk, 2003; Kaufman Kantor & Straus, 1987; Moore et al., 2008; Watkins, Maldonado, & DiLillo, 2014) and thus curbing recidivism may rely in part on curbing substance use. Yet, many BIPs require that substance abuse problems be addressed prior to enrollment into the program (Buzawa et al., 2012). This is particularly salient, as Buzawa and colleagues (2012) explained, “most reoffending occurs long before substance abuse can be totally resolved (p. 360).” Some BIPs require batterers with substance abuse problems to simultaneously attend an abuse program. However, this does not seem to characterize the majority of programs, as Shepard and Pence (1999) noted, “carefully thought-out concurrent treatment for substance abuse is a rarity rather than a rule” and “neither battered women nor offenders may be served well by this lack (p. 136).”

Additionally, some BIPs gather information from a variety of sources (e.g., police and probation reports, criminal history files, interviews with offenders/victims) during the intake process of enrollment (Sonkin, Martin, & Walker, 1985). Many known predictors of DV (also criminogenic needs), such as antisocial behavior (Lussier et al., 2009), drug and alcohol abuse (Moore et al., 2008; Raskin White & Chen, 2002), anger and hostility (Norlander & Eckhardt, 2005), and marital conflict (Aldarondo & Sugarman, 1996) are assessed at this point. Thus, BIPs which conduct assessments that evaluate criminogenic needs at the initial stages of enrollment are partially engaging in “best practices” and following the need principle. As Gondolf (2012)

has noted, though, there seems to be little agreement regarding what to do with this information in BIP treatment after it is assessed.

Three main conclusions can be taken from our analysis of how the need principle is currently implemented in batterer intervention programming. First, some BIPs center their attention on changing attitudes held by the offender; however, the attitudes of focus are not antisocial ones (e.g., the belief that it is okay to take what the batterer wants using force) and instead tend to revolve around males' general views of women. Second, BIPs recognize the co-occurrence of DV and substance abuse, although many programs are not equipped to address their comorbidity. Lastly, while several BIPs conduct intake assessments that tap into criminogenic needs, these programs are not utilizing the information to its full potential (e.g., using assessments to identify low, medium, and high-risk groups or to identify the most salient criminogenic needs to target during treatment).

The Responsivity Principle within Current Batter Intervention Programming

Recall that the responsivity principle holds that treatment services should accommodate an offender's learning style, ability, and strengths, as well as be cognitive-behavioral in nature (Bonta & Andrews, 2007). Some elements of BIPs – knowledge of the factors associated with batterer attrition and the use of structured programming – indicate that the responsivity principle is partly evident in BIPs today. To demonstrate, numerous factors that influence batterer attendance have been identified (Bennett, Stoops, Call, & Flett, 2007; Cadsky, Hanson, Crawford, & Lalonde, 1996; Hamberger, Lohr, & Gottlieb, 2000; Jewell & Wormith, 2010): offender perceptions (Heckert & Gondolf, 2000), referral sources (Barber & Wright, 2010; Dalton, 2001), education (Daly, Power, & Gondolf, 2001; Stalans & Seng, 2007), anger (Chang & Saunders, 2002), age, race, and income (Buttell & Carney, 2008; Taft, Murphy, Elliott, & Keaser, 2001),

immigrant status (Rothman, Gupta, Pavlos, Dang, & Coutinho, 2007), and program characteristics (Rooney & Hanson, 2001). For instance, Taft and colleagues (2001) determined that an offender's employment status, education level, number of prior arrests, and race were all significant predictors for the number of sessions he attended, and an offender's referral source and race were significant predictors for treatment completion. Findings from a study by Rooney and Hanson (2001) indicated that offenders with unstable lifestyles (e.g., substance abuse problems, criminal history, unstable living arrangements) were more likely to dropout from a program than offenders with more stable lives. Furthermore, they reported that offenders with low verbal skills were more likely to dropout of unstructured programs than low verbal aptitude offenders in more structured programming (e.g., cognitive-behavioral, follow a treatment manual, present curriculum in a consistent, organized fashion).

Two inferences can be made from the body of this literature. First, BIPs that offer structured programs are addressing general responsivity. Second, there are numerous specific responsivity factors, such as program and offender characteristics that may impede or encourage successful completion of a program, which BIPs may address during treatment. The degree to which this is done, however, is largely unknown.

The Treatment Principle within Current Batter Intervention Programming

As mentioned, the treatment principle suggests that treatment services utilize cognitive social learning strategies (e.g., modeling, cognitive restructuring), and be delivered by firm-but-fair staff (Andrews & Bonta, 2010; Andrews, Bonta, et al., 1990). Many components of the treatment principle, including the use of cognitive-behavioral approaches, program intensity, and/or treatment length, have been infused into current BIPs. Because BIPs tailor their approaches to account for their unique needs and resources, it is difficult to directly compare

programs, but many have a cognitive-behavioral foundation (Gondolf, 2002). In a meta-analytic examination of over 40 studies, Gondolf (2004) concluded that the effectiveness of a program depends largely on its interventional approach, and that the gender-based cognitive-behavioral approach “seems to be appropriate for the majority of men (p. 623).” Even if not fully identified as a cognitive-behavioral BIP, several programs employ elements of social learning strategies and cognitive-behavioral techniques into their program designs (Babcock et al., 2004; Eckhardt et al., 2013; Pence & Paymar, 1993). For example, as Babcock and colleagues (2004) explain, “To the extent that CBT groups address patriarchal attitudes, and Duluth model groups address the learned and reinforced aspects of violence, any distinction between CBT and Duluth model groups becomes increasingly unclear (p. 1026).”

The treatment principle within BIPs is also found in their program duration. Many BIPs are governed by state standards, which dictate program characteristics such as treatment modalities and services, program duration, curriculum content, and program philosophy (Maiuro & Eberle, 2008). In an examination of state standards regarding BIPs, Maiuro and Eberle (2008) determined that treatment length varied from 3 months to over one year, with the majority of programs lasting from 24 to 26 weeks. Additionally, the majority of programs met on a weekly basis for one to two hours (Maiuro & Eberle, 2008).

Two main points can be drawn regarding the current integration of the treatment principle into batterer intervention programming. First, some batterer interventions are employing a cognitive-behavioral approach or are utilizing social learning techniques within their curriculum. Second, BIPs, for the most part, are adhering to the treatment principle with regards to length of treatment.

The Fidelity Principle within Current Batter Intervention Programming

Recall that the fidelity principle asserts that well-trained, qualified personnel operate treatment services, the program should be implemented as it was designed, and services should be routinely assessed and evaluated for effectiveness (Andrews, 2006; Latessa & Holsinger, 1998). Several elements of the fidelity principle exist within current batterer intervention programming today: personnel requirements based on education, training, and personality characteristics, and the inclusion of an evaluation component.

Many BIPs employ staff who are formally educated, and many states require staff to meet continuing educational requirements (Maiuro & Eberle, 2008). In addition to educational requirements, some BIPs require that personnel attend training sessions/workshops that focus directly on DV-related issues (Sonkin et al., 1985). Moreover, many BIPs outline general ethical criteria to which staff must abide (Austin & Dankwort, 1999; Maiuro & Eberle, 2008). For instance, in a review of state standards regarding BIPs, Austin and Dankwort (1999) reported that many states required staff to be free of substance abuse problems, live non-violent lifestyles, and subscribe to non-sexist attitudes.

Several BIPs also incorporate evaluations into their programming (Austin & Dankwort, 1999; Maiuro & Eberle, 2008; Pence & Paymar, 1993; Sonkin et al., 1985). The popular feminist-based Duluth model guidelines require that BIPs evaluate their programming across many levels, including the implementation of policies, the impact of intervention, and recidivism outcomes (Pence & Paymar, 1993). In their approach to the treatment of male batterers, Sonkin and colleagues (1985) indicated that program evaluation is an important component in determining what is effective and not effective when working with batterers. Despite this, they fail to elaborate on how to conduct the evaluations, as well as how frequently they are to be done. In fact, it is not uncommon for many BIPs to be required, as outlined by state standards, to

conduct evaluations (Austin & Dankwort, 1999; Maiuro & Eberle, 2008). However, many state guidelines and standards lack adequate explanation as to when and how evaluations are to be conducted (Austin & Dankwort, 1999).

Two noteworthy conclusions regarding program fidelity can be drawn from this discussion. First, the majority of BIPs have standards that outline staff requirements. Second, while many BIPs are required to have an evaluation component, there appears to be a disconnect between its acceptance in theory and its actual application.

Recommendations for Further Integrating the Principles of Effective Intervention into Batterer Intervention Programs

It is in the best interest of a community and its individuals to pursue ventures that reduce recidivism. Hence, it is important to further integrate the PEI into BIPs as recidivism reduction leads to decreased crime and its associated costs (e.g., victim safety and compensation, judicial proceeding fees, etc.). And while such ventures are ideal, further integration of the PEI into batterer intervention programming may initially be costly and time intensive, and may require a change in the way things have been done. However, despite these challenges, the outcomes of such integration are cumulatively beneficial. Still, BIPs do not exist within a vacuum. We understand that the following recommendations may be difficult to integrate into real-world practice. These recommendations are intended to stimulate thoughts, considerations, and discussions related to the integration of PEI into batterer intervention programming.

The Risk Principle

To integrate the risk principle more fully into batterer intervention programming, it is recommended that BIPs begin to (or continue to) employ and use a risk assessment tool to determine the risk level of a batterer prior to his enrollment within the program. BIPs should utilize DV risk assessment tools that best predict the outcome in which they are most interested

(e.g., a batterer's likelihood of reoffending). However, it is important to note that current risk assessments and typologies are largely based on different definitions of risk – to our knowledge, no standardized measure of risk for DV has been agreed upon. Additionally, while some current DV risk assessments (e.g., ODARA, SARA) are promising, they nonetheless are limited in their power at predicting DV recidivism. More research is needed to establish a standardized measure of risk for DV recidivism and create a standardized tool to use across BIPs so that offenders can be placed into low-, medium-, and high-risk categories. In the meantime, because some tools may already be used by BIPs, and since many utilize measures of violence to identify batterer typologies, BIPs could consider using them to inform categories of low-, medium-, and high-risk offenders.

After risk levels are determined, BIPs should focus their resources on high-risk offenders, as research has shown they will benefit most from the intensive treatment. If services are provided to low- and medium-risk offenders, we recommend that BIPs treat these offenders separately from high-risk offenders, because administering high intensity treatment to these lower risk offenders can have negative effects, such as increased reoffending (Lowenkamp, Latessa, & Holsinger, 2006).

Consequently, there are multiple advantages to employing and utilizing risk assessment tools correctly within BIPs. First, treatment targeted to high-risk offenders will likely yield higher recidivism reductions, which is a primary goal among BIPs. Second, as research has indicated, low-risk offenders will not be exposed to programming (or other offenders) that may result in increasing their likelihood to reoffend. Lastly, by focusing on high-risk offenders and ensuring offenders receive the appropriate level of service, BIPs would be able to invest the limited funds they have in a more efficient and cost-beneficial way.

The Need Principle

To incorporate the need principle into batterer intervention programming, it is suggested that a full list of criminogenic needs, especially those “central eight factors” be targeted for change.⁷ BIPs should begin (or continue) to uniformly assess known criminogenic needs during the enrollment process with the batterer. Once the criminogenic needs are identified, BIPs should then address the offender’s most problematic ones during treatment. For example, feminist-based programs that place heavy emphasis on changing general patriarchal attitudes should shift their attention towards altering the specific antisocial attitudes of batterers. Likewise, to address the criminogenic need of substance abuse, BIPs should make substance abuse counseling an integral part of the program. BIPs can provide substance abuse counseling in one of two ways. One suggestion is to have BIPs augment their curriculum to incorporate an additional component specifically for chemically dependent offenders. An alternative suggestion is for the BIP to work in tandem with substance abuse programs, wherein the two programs work closely together to reduce the violence and chemical dependency simultaneously (Easton et al., 2007). Another strong criminogenic need factor is low social support. BIPs that attempt to strengthen prosocial supports from others, for example, by strengthening the bonds between family members and the batterer, may see benefits in the way of reduced recidivism. The final recommendation is for BIPs to target as many criminogenic needs as possible during the administration of services. This is because, as mentioned, research findings have indicated that reductions in recidivism increase with the number of criminogenic needs being met through treatment. Subsequently, the application of these prescribed recommendations to BIPs will likely result in reduced rates of recidivism.

The Responsivity Principle

As empirical evidence has indicated, several responsivity factors are or could be impeding treatment completion in BIPs. Evidence in both correctional and batterer intervention literature has indicated that a more structured program is more effective than a less structured program. Therefore, it is recommended that BIPs follow a structured methodology (e.g., cognitive-behavioral, follow a treatment manual, present information in a concrete and distinct manner) (Rooney & Hanson, 2001). It is also widely accepted that there is variation within offenders, as scholars have identified several typologies of DV perpetrators. It is possible that different types of offenders have specific responsivity problems, which in turn may need to be addressed via different treatment approaches. For instance, intimate terrorists may respond to treatment differently than situational violent offenders (Johnson, 2008), and altering treatment to be more appropriate for this subgroup of offenders may increase the overall effectiveness of the BIP. Despite understanding that different types of batterers exist, BIPs consistently provide the same treatment to all batterers, which directly violates the responsivity principle (and in some cases, the risk principle, too). Therefore, it is recommended that BIPs place emphasis on identifying programmatic and offender characteristics that are linked to treatment success (treatment completion as well as later recidivism) and employ services that address them properly.

BIPs frequently determine treatment success based on an offender's completion or dropout status. While this outcome is important, it is recommended that BIPs consider other outcomes of treatment success as well. For example, specifically regarding the responsivity principle, BIPs need to evaluate what offenders actually learn in treatment. These evaluations would identify potential responsivity issues that have not been previously considered (e.g., intelligence levels, verbal aptitude) that could prevent offenders from fully capturing the

program's purpose, leading to diminished treatment success (e.g., dropout or recidivism). We recommend that BIPs evaluate programmatic outcomes (e.g., what did an offender learn?) as well as long-term recidivism outcomes (e.g., did the offender recidivate within 6 or 12 months?) as they relate to responsivity factors.

The nature of specific responsivity appears to lend itself to a more individualistic approach to treatment as opposed to group-based treatment often found in BIPs. However, the responsivity principle has been found in group-based programs in corrections (Van Voorhis & Salisbury, 2014; Van Voorhis et al., 2004; Van Voorhis, Spruance, Ritchie, Listwan, & Seabrook, 2002), and will likely translate to group-based BIPs as well.

BIPs that adhere to these recommendations will likely encounter many benefits. First, programs that strategically place matched treatment styles and modes to offender learning capabilities together will likely see greater reductions in recidivism. Second, BIPs that adequately address known responsivity factors which affect attrition will presumably have higher rates of completion than programs that do not or ineffectively attend to responsivity factors. Finally, programs that evaluate what offenders are learning from the treatment will enable them to identify latent responsivity factors and then appropriately adjust the programming to address such factors; this will likely increase its overall treatment success.

The Treatment Principle

To continue the incorporation of the treatment principle into BIPs, we recommend that all BIPs follow the cognitive-behavioral approach. This would entail programs that place primary focus on other approaches (e.g., psychodynamic) to restructure their curriculum in order to adhere to the cognitive-behavioral approach as their dominant framework. While some BIPs already partially employ various cognitive-behavioral techniques in treatment, we recommend

that they embrace the approach as their main guiding framework. We also recommend that all programs begin utilizing social learning strategies (e.g., role playing, skill building, problem solving) in their curriculums. Lastly, while we recognize that the majority of programs already comply with the three to nine month treatment duration guideline that is outlined by the treatment principle, we suggest that all programs restructure to meet this time frame for treatment length and intensity.

Two key benefits are expected for BIPs that fulfill the requirements of the treatment principle. First, as research studies have indicated, adhering to the cognitive-behavioral approach for treatment services will likely yield higher rates of recidivism reduction. Second, by bringing all BIPs to the same standards of treatment duration and the use of social learning techniques, standardization across BIPs can be met more effectively, making treatment, evaluation, and comparisons more easily accomplished.

The Fidelity Principle

To integrate the fidelity principle into BIPs, staff training and program evaluations must be addressed. We recommend that BIPs continue to have standards that outline staff expectations/guidelines, and require that staff have formal training as well as on-the-job training that encompasses a variety of “best practices” topics on an annual basis. It is essential that staff be trained on EBPs as they relate to BIPs and DV offenders. Staff should also be trained regarding how to properly administer, interpret, and utilize the risk assessment tool in the BIP. It is also imperative that staff members become knowledgeable regarding the types of offenders attending BIPs, as well as the responsivity factors associated with them. Additionally, staff should be trained on the risk factors and criminogenic needs which should be targeted for change

in treatment in order for recidivism to be reduced (e.g., predictors of attrition, predictors of DV recidivism).

As noted earlier, several BIPs are required to incorporate evaluation into their program design; however, there is a lack of specificity as to what, how, and when evaluations should be (or are) carried out. We recommend that all BIPs build regular evaluation components into their program designs. First, BIPs must conduct process evaluations, which will assess how well the treatment services are doing in reaching the program's intended goals. Second, BIPs should administer outcome evaluations that focus on both short- (e.g., does the program increase treatment completion?) and long-term (e.g., does the treatment reduce recidivism?) outcomes. The program should also be assessed regarding how closely it follows its intended design and implementation (program integrity) as well as how well it adheres to the PEI. Furthermore, due to the clandestine nature of DV, we recommended that evaluations geared to assess recidivism should employ both official measures as well as victim self-reports of reoccurrences of DV.

We also recommend that BIPs establish (or update) a program handbook to be distributed to all of their personnel. The handbook should provide guidelines and procedures related to the requirements outlined by the program. For example, the handbook should address requirements regarding the amount and type of training needed by personnel, as well as provide guidelines as to how often training is to be completed. Of importance, the PEI as they apply and are implemented within BIPs should be outlined in these manuals. The handbook should also provide specific details related to the evaluation components of the program. For instance, the handbook should dictate what types of evaluations need to be completed (and why), how the evaluations are to be conducted, and how often they are to be completed.

There are numerous potential benefits for BIPs that comply with these recommendations. Such advantages include a decreased number of batterers that dropout of the BIP, which will presumably result in higher rates of treatment effectiveness for a greater number of batterers. Additionally, programs that incorporate regular process and outcome evaluations will be able to assess and adjust their programs to improve areas that may be previously lacking in quality or effectiveness.

Conclusion

We recognize that some of our recommendations are lofty and likely drastic, which may be met with organizational and philosophical pushback. Within this resistance, several practical and philosophical barriers may arise. Potential practical barriers may include monetary resources, effort, and time. In many cases, BIPs are limited in monetary resources. A multitude of programs are funded by various sources, such as the fees paid by the batterers, state funding (which may be subject to budgetary cutbacks), fundraising efforts, and donations. Additionally, BIPs are often housed within non-profit associations (e.g., women's centers) where time and resources are regularly stretched thin, staff and personnel have high turnover rates, and there is heavy reliance on the assistance of volunteers. These barriers present resistance primarily because each of the recommendations provided require financial backing, as well as increased training, qualifications, and time required of staff.

Philosophically, some scholars and practitioners may hold the stance that DV offenders are unique offenders who specialize only in DV-related crime. They may therefore believe that applying principles founded from studies on general offenders will not apply to DV offenders. Some individuals may agree with the PEI but disagree with its application to BIPs. For example, the risk principle requires that low and medium risk offenders receive little to no treatment;

however, some may fundamentally believe that low risk offenders should receive the most attention in treatment. Others may believe that the intended goals of a BIP reach beyond simple recidivism measures. Indeed, though the intended collective goal of a BIP is to reduce DV recidivism, other goals may exist within a program, such as its participation in a coordinated community response to DV, offender accountability, and victim safety. While additional goals may be important, our recommendations focus on the goal of reduced recidivism. Stakeholders and researchers alike may resist the recommendations provided if they place higher emphasis on other goals. We are not suggesting that change will be easy, but we believe a significant paradigm shift in how BIPs have operated in the past to a way that encompasses more of an evidence-based approach is needed and would be a worthy endeavor.

In addition to the aforementioned barriers, some might fear that the infusion of PEI into BIPs may stifle innovation to further improve BIPs. We acknowledge that there may be other promising programs, but we believe that the PEI provide the most empirically sound avenue to pursue at this point. Furthermore, we attest that research on PEI within battering programming may actually facilitate more innovation rather than stifle it.

Although some aspects of the PEI have been evaluated in BIPs (e.g., culture/race as a responsivity factor), they have not been evaluated under the framework of the PEI nor have there been (to our knowledge) formal published evaluations of the PEI in BIPs to date. Work in this area is needed, and we recommend that future researchers empirically examine the PEI as they are found in BIPs. Furthermore, we assert that the PEI should be evaluated and assessed within BIPs before fully integrating the PEI into BIPs on a large scale or making any significant policy changes. As mentioned, the aim of this manuscript is to be a starting point for discussing the integration of the PEI into BIPs.

In sum, it is apparent that BIPs are in need of improvement. This manuscript has provided one way in which betterment of BIPs can be achieved. We believe that the overwhelming evidence from correctional rehabilitation programming with other types of offenders (e.g., violent or substance users) demonstrates strong support for integrating the PEI into BIPs across the country. We suggest that the potential benefits far outweigh the potential pitfalls and philosophical pushback. And while we recognize that such recommendations will not be easy, the evidence suggests that borrowing elements of EBPs found in correctional intervention programming and applying them to BIPs would be valuable to all who are involved (e.g., offender, victim, community). In the end, it is imperative that we try.

Table 1: The Principles of Effective Intervention and Batterer Intervention Programs

Principle of Effective Intervention	The Principle within Correctional Programming	The Principle within Current Batterer Intervention Programming	The Principle within Future Batterer Intervention Programming
Risk	<p><i>Risk assessments</i></p> <ul style="list-style-type: none"> • Offenders are classified into low, medium, high-risk categories • Offender are matched with the appropriate intensity of treatment • Target high-risk offenders • Low-risk offenders receive minimal to no services 	<p><i>Intake assessments</i></p> <ul style="list-style-type: none"> • Identifies chemically dependent or special needs offenders • Some risk assessments are used to identify recidivism risk 	<p><i>Risk assessments</i></p> <ul style="list-style-type: none"> • Employ and use a risk assessment • Classify batterers into low, medium, and high risk • Match the level of batterer with the corresponding level of treatment intensity • Target high-risk batterers • Low-risk batterers receive minimal to no treatment
Need	<p><i>Criminogenic needs</i></p> <ul style="list-style-type: none"> • Identify dynamic, criminogenic needs • Address and focus attention on criminogenic needs within treatment • Focus primarily on “central eight” need factors, or those most strongly related to recidivism 	<p><i>Attitudinal changes</i></p> <ul style="list-style-type: none"> • Feminist-based programs seek to change men’s patriarchal views <p><i>Comorbidity with substance abuse</i></p> <ul style="list-style-type: none"> • BIPs are aware of the correlation between DV and substance abuse, particularly alcohol <p><i>Intake assessments</i></p> <ul style="list-style-type: none"> • Current intake assessments assess some criminogenic factors (e.g., substance abuse, marital/familial relationships) 	<p><i>Criminogenic needs</i></p> <ul style="list-style-type: none"> • Identify criminogenic needs during the intake assessment • Address and focus attention on criminogenic needs that are known to affect treatment effectiveness and DV recidivism • Develop a strategy for how to address chemically dependent batterers that works in sync with the batterer treatment services
Responsivity	<p><i>General responsivity</i></p> <ul style="list-style-type: none"> • Treatment structure that follows cognitive social learning strategies <p><i>Specific responsivity</i></p> <ul style="list-style-type: none"> • Address specific offender characteristics that may influence his ability to successfully complete the program 	<p><i>Styles and modes of service</i></p> <ul style="list-style-type: none"> • BIPs understand that structured programs work better for some batterers than unstructured programs <p><i>Factors that affect treatment completion</i></p> <ul style="list-style-type: none"> • BIPs are aware of factors that affect treatment completion; however, programs continue to treat batterers as a monolithic group 	<p><i>General responsivity</i></p> <ul style="list-style-type: none"> • Cognitive-Behavioral treatment is delivered in a structured manner • The styles and modes of service are to match an offender’s capabilities and learning style <p><i>Specific responsivity</i></p> <ul style="list-style-type: none"> • Identify and subsequently address responsivity factors that affect attrition • Conduct regular evaluations of what is being learned by the batterers, and potentially identify latent responsivity factors

Table 1 (Continued): The Principles of Effective Intervention and Batterer Intervention Programs

Principle of Effective Intervention	The Principle within Correctional Programming	The Principle within Current Batterer Intervention Programming	The Principle within Future Batterer Intervention Programming
Treatment	<p><i>Treatment approach</i></p> <ul style="list-style-type: none"> • Cognitive-behavioral in nature • Employs the use of social learning techniques <p><i>Treatment structure</i></p> <ul style="list-style-type: none"> • 40-70% of an offender’s time within the program is dedicated to intense treatment services • Length of treatment should fall within a 3 to 9 month time frame 	<p><i>Treatment approach</i></p> <ul style="list-style-type: none"> • Feminist-based • Psychodynamic • Cognitive-behavioral • Programs are often unique, in that one program may employ several facets of various approaches at one time <p><i>Treatment structure</i></p> <ul style="list-style-type: none"> • 3 months to over 1 year • Weekly meeting lasting roughly 1-2 hours 	<p><i>Treatment approach</i></p> <ul style="list-style-type: none"> • Cognitive-behavioral in nature • Employs the use of social learning techniques <p><i>Treatment structure</i></p> <ul style="list-style-type: none"> • Treatment is roughly 26 weeks in length • Treatment services are provided on a weekly basis, lasting 90 minutes to 2 hours
Fidelity	<p><i>Quality of staff</i></p> <ul style="list-style-type: none"> • Firm-but-fair • Respectful • Competent <p><i>Training of staff</i></p> <ul style="list-style-type: none"> • Skilled in computer work, paperwork, and problem solving • Properly trained • Monitored <p><i>Evaluation</i></p> <ul style="list-style-type: none"> • Focused on program integrity • Program implementation assessments • Offender assessments of learned material 	<p><i>Quality of staff</i></p> <ul style="list-style-type: none"> • No substance abuse problems • Live non-violent lives • Hold non-sexist attitudes <p><i>Training of staff</i></p> <ul style="list-style-type: none"> • Formally educated • On-the-job training <p><i>Evaluation</i></p> <ul style="list-style-type: none"> • Outlined as part of the program design • Lack of clarity in what an evaluation is, how it is to be administered, and when evaluations are to be conducted 	<p><i>Quality of staff</i></p> <ul style="list-style-type: none"> • Firm-but-fair • Respectful • Have no substance abuse problems • Live non-violent lives • Hold gender-neutral attitudes • Competent • Skilled in computer work, paperwork, and problem solving <p><i>Training of staff</i></p> <ul style="list-style-type: none"> • Formally educated and receive continuous on-the-job training <ul style="list-style-type: none"> • Knowledgeable on types of DV offenders • Knowledgeable of PEI and how they are implemented in BIPs • Knowledgeable of responsibility factors • Understand the characteristics of an offender that must change in order for recidivism to be reduced (e.g., predictors of attrition, predictors of DV recidivism) • Trained in the implementation, administration, interpretation, and utilization of the risk assessment tool <p><i>Evaluation</i></p> <ul style="list-style-type: none"> • Regular, built-in evaluations to assess: <ul style="list-style-type: none"> • Implementation to the original design and to the adherence of the PEI • Process evaluations • Outcome evaluations

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Footnotes

1. Throughout the remainder of this manuscript, “correctional” services, populations, and treatments refer to offender-based rehabilitative services, programs, and interventions found within institutional and community settings.
2. We focus on BIP treatments that center on male batterers instead of female batterers in this review.
3. Although BIPs may treat batterers who were sanctioned by the criminal justice system and those who attend voluntarily, we maintain that the majority of batterers in BIPs have been sanctioned to participate.
4. Most correctional program evaluations with general offenders focus on recidivism as measured by official statistics. However, DV recidivism is often measured by official statistics as well as self-reports from victims, given that most DV occurs in private settings and away from the public eye (Gondolf, 2002; Straus, Gelles, & Steinmetz, 2006).
5. Therapeutic integrity sometimes refers to the qualifications, training, skill sets, and supervision of staff, while program integrity has been used to refer to how closely the program is implemented in practice to its original design. The term “fidelity” is a broad term meant to encompass both the program implementation and design, as well as staff delivery of services.
6. It is important to note that studies which examine the link between attitudes and behavior have mixed findings. For a further description of how the correlation between attitudes and behavior relates to criminogenic needs see pp. 236-237 of Andrews and Bonta (2010).
7. A review of the predictors of DV recidivism may highlight additional criminogenic needs that should be addressed in treatment.