DOMESTIC VIOLENCE PERPETRATOR TREATMENT

A Proposal for an Integrated System Response (ISR)

Report to the Washington State Legislature

June 2018

June 26, 2018

To the Legislature:

It is the honor of the E2SHB 1163 Section 7 work group to present the requested report concerning perpetrator treatment in cases of Domestic Violence. After nearly a year of meetings, collaborative discussion, and writing, the work group chairs wish to acknowledge the fine work of every one of the active work group members.

The work group was ably supported by staff from the Administrative Office of the Courts (AOC) and the Supreme Court's Gender & Justice Commission, most particularly by Ms. Laura Jones, J.D.

All of the work group members look forward to working with the Legislative, Executive, and Judicial branches to enable the recommendations for substantial improvements to responses essential for the protection of victims of domestic violence and our communities around the State of Washington.

JUDGE ERIC LUCAS, Member Gender & Justice Commission
E2SHB 1163 Work Group Co-Chair
Snohomish County Superior Court

JUDGE MARILYN PAJA, Vice-Chair Gender & Justice Commission
E2SHB 1163 Work Group Co-Chair
Kitsap County District Court

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EXECUTIVE SUMMARY

Problem Description

On May 10, 2017, the Governor signed Engrossed Second Substitute House Bill 1163, hereafter referred to as HB 1163, into law. The law is a response to the problem of domestic violence, described in the bill reports as addressing "repeat" domestic violence (DV) offenders. The Senate Bill Report poignantly summarized the public's testimony when it said:

> The main thrust of this bill is to hold repeat DV offenders accountable…. ***DV offenders are the most dangerous offenders we deal with and have the highest recidivism rates among offenders. Fifty-four percent of mass shootings are related to DV and police are three times more likely to be murdered responding to a DV call than any other call with shots fired. Progression of violence is prevalent among offenders***…. DV is more prevalent than people realize. Many offenders have been perpetrating violence long before they are brought into court and the victim has been living with this behavior for a significant period of time…. Washington is in the extreme minority in how it treats DV offenders when compared to other states. Forty-three states have sentencing enhancements for repeat DV offenders...Washington is not treating these assaults with the priority level that they deserve. (Emphasis added).

HB 1163 focuses on six areas. The bill:

1. Elevates Assault in the fourth degree involving domestic violence (DV) from a gross misdemeanor to a class C felony based on repeat criminal history.

2. Counts prior adult convictions for Assault of a Child or Criminal Mistreatment involving DV as two points when calculating criminal history.
3. Requires deoxyribonucleic acid (DNA) collection from offenders when convicted of DV Assault 4th degree.
4. Provides that sheriffs may waive fees on writs of habeas corpus for return of a child when poverty would prevent payment.
5. **Requires the Washington State Gender and Justice Commission to convene work groups to address the issues of DV perpetrator treatment and DV risk assessment.**
6. Provides that, with some exceptions, a vacated misdemeanor or gross misdemeanor DV conviction cannot be used in a later criminal prosecution.

The convening of the domestic violence "work groups" is therefore an essential element of how the new law endeavors to address the problem of domestic violence.

Our Recommended Solution: Integrated System Response (ISR)

This report summarizes the results of the Section 7 Perpetrator Treatment Work Group (henceforth the "PTWG" or "Work Group"). The Work Group has identified a new process to be used to pursue Perpetrator Treatment. This process fulfills our assigned tasks, which were to:

a. "Review laws, regulations, and court and agency practices pertaining to domestic violence perpetrator treatment used in civil and criminal contexts, including criminal domestic violence felony and misdemeanor offenses, family law, child welfare, and protection orders;
b. Consider the development of a universal diagnostic evaluation tool to be used by treatment providers and the department of corrections to assess the treatment needs of domestic violence perpetrators; and
c. Develop recommendations on changes to existing laws, regulations, and court and agency practices to improve victim safety, decrease recidivism, advance treatment outcomes, and increase the courts' confidence in domestic violence perpetrator treatment."

After much discussion regarding the statutory charge to: "Review laws, regulations, and court and agency practices…pertaining to perpetrator treatment," the PTWG agreed that this language required us to map the system. This was our agreed starting point. Our mapping effort had three identifiable results: 1) We identified the Domestic Violence Bench Guide[1] as a mapping resource; 2) We identified the Social Workers Practice Guide to Domestic Violence[2] as a mapping resource; and 3) We created a mapping document to structure our work and focus our critique of the current treatment regime.

[1] Appendix A
[2] Appendix B

Accordingly, the PTWG has identified the following primary problems related to DV treatment practices:

1. Definition of DV behaviors: Individuals are ordered into DV intervention based on a definition that can lead to individuals with significantly different needs being placed into the same intervention program. Moreover, behaviors in the legal definition of domestic violence are narrowly defined.
2. The system has no uniform way of collecting treatment-related data for analysis regarding the efficacy of treatment and how to improve the system.
3. There is no comprehensive way to gather the crucial information from the myriad sources necessary to make an adequate assessment.
4. There are no treatment alternatives for DV crimes—DOSA and SSOSA do not include a DV treatment response, i.e., there is no DVOSA.
5. Adequate monitoring and enforcement of treatment is required; treatment cannot work if a perpetrator is not required to complete it.
6. Family law settings require a motion for contempt to enforce ordered DV treatment interventions, placing the burden of compliance on the victim.
7. The financial cost of DV treatment often creates situations of treatment noncompliance.
8. There is a lack of DV treatment providers in general in our state, and there is limited access to DV treatment in more rural areas of the state.

9. Access to culturally competent DV treatment is also limited and hampers compliance.
10. Training is unstructured and sporadic among law enforcement, prosecutors, judges, and other professionals in the area of domestic violence, which creates an inability to deliver best practices.

Most of the above-listed issues are not related to treatment modality, but to the system response to treatment. As such, we must view treatment in a manner that "integrates" it with the rest of the system. The PTWG calls this an "Integrated System Response," (ISR). One group member described the problem as follows:

> The work that treatment providers do has never been intended to be a stand-alone intervention or type of treatment. The idea is that consistent messages from a person's family, program, as well as other parts of the total system such as judiciary, must send the message externally that this behavior is not ok and needs to change. There needs to be a whole system analysis.

Although our state is now undergoing a process to upgrade and adopt new regulations governing domestic violence perpetrator treatment[3], we currently have a "one size fits all" treatment regime, which is largely seen as unsatisfactory and in need of correction.

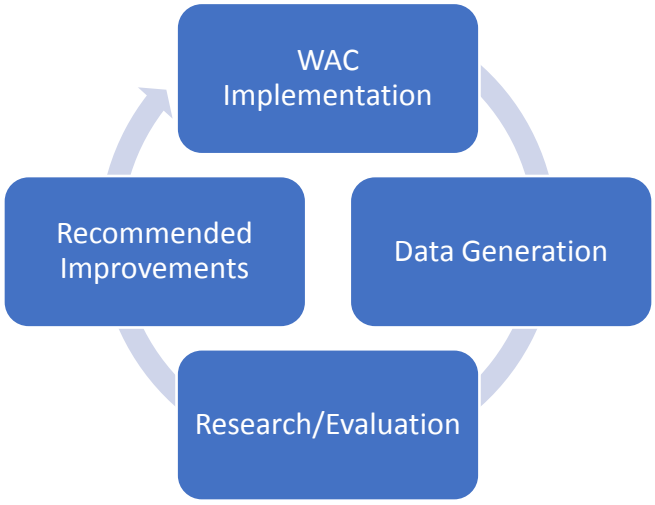
As such, the Work Group has concluded that an adequate starting point for the needed new process exists in the description of the treatment protocol changes required in the new Chapter 388-60A WAC[4]. The consensus of the PTWG is to embrace the approach it takes toward DV Perpetrator Treatment. Primarily, the new WAC

[3] https://www.dshs.wa.gov/sesa/policy-and-external-relations/rules-and-policies-assistance-unit
[4] The adoption date for Chapter 388-60A WAC is June 29, 2018.

eliminates the prior "one size fits all" treatment regime, replacing it with a multi-level treatment approach, the modalities of which implement evidence-based practices.

However, we must emphasize that the new WAC is just a starting point. Our consensus necessarily includes a requirement for additional research on WAC implementation, because the proposed WAC is new and not yet "evidence-based." The process we describe herein is intended to create a complete evidence-based DV treatment system in Washington State.[5]

Our proposal is both a short-term and long-term solution. Short-term in the sense that the new WAC will be effective within weeks of this report, but long-term in the sense that it will take an as yet undefined amount of time (perhaps years) to reach the goal of a completely evidence-based system for DV perpetrator treatment. The feedback loop will take time to work:



[5] This article advocates for more evidence-based domestic violence treatment programming: Radatz and Wright, "Integrating the Principles of Effective Intervention into Batterer Intervention Programming: The Case for Moving Toward More Evidence-Based Programming," Trauma, Violence & Abuse 1-16 (2015).

Our process, if accepted, necessarily means a long-term statewide commitment to improving DV perpetrator treatment.

In accordance with the above-described problem, the Work Group has concluded after consideration, that emphasis on a universal diagnostic tool is not essential to assessment for treatment. Instead, we find that assessment and diagnosis are what we consider a multi-source informational problem and that the "universality" of the diagnostic tool is irrelevant. What is of critical import in the task of assessment and diagnosis is the quality of information on which assessment and diagnosis is based.[6]

In sum, to make an Integrated System Response (ISR) to treatment effective, we recommend that the following essential systemic changes be made:

1. **Propagate evidence-based DV treatment statewide by creating a multi-level treatment environment which requires providers adhere to, and perpetrators meet, identified core competencies.**
2. **Designate DV Treatment as a Therapeutic Court function and deliver treatment via that model. The specific structure should be selected by the local jurisdiction. At a minimum, the following structural models are available: Multi-disciplinary Team; Probation/Supervision; and Calendar Review (DOSA-like).**

[6] Quality of information is an Integrated System Response (ISR) problem. Assessment and diagnosis are placed at risk if the quality of the information is suspect. If the sources of the information utilized are omitted, distorted, corrupted or biased, the resulting assessment and diagnosis, will not be reliable.

3. **Ensure high-quality systemic information by enabling Therapeutic Courts to function in the system as a "statewide" information repository.**[7]
4. **Monitor our system's performance, focusing on continuous improvement, by enabling on-going data collection, rigorous research and future adaptation of our new Washington State DV treatment system, towards the goal of a completely evidence-based system.**
5. **Create a reliable funding scheme for all court-ordered treatment.**[8]
6. **Provide training and resources to professionals working in the area of Domestic Violence. This training must necessarily include a culturally relevant focus.**

In the following sections of this report, we discuss the details of these proposals including current laws, regulations, and agency practices related to our system of Domestic Violence Treatment. These sections also include detailed Work Group recommendations to improve the existing system infrastructure.

[7] In our view, the most promising institution for such a repository is the court system, within its probation/community supervision function.
[8] The new ISR process contemplates a new routine or "court-calendar" wherein all DV treatment ordered would be regularly monitored (supervised) whether criminal, or civil in nature. DV treatment requirements in dependencies are already court-monitored.

INTRODUCTION

Background and Report Objectives

HB 1163 created a new recidivist domestic violence (DV) offender crime, DNA profiling of misdemeanor DV assault offenders, and legislative workgroups to focus on treatment and risk, and was signed into law on May 10, 2017. Lead sponsor, Representative Roger Goodman, Chair of the House Public Safety Committee, spent three years advocating for passage of HB 1163. This legislation simultaneously creates a new recidivist law that will impact repeat domestic violence offenders, while also bringing together professionals across the state to address risk and offender treatment needs, in hopes of reducing the need for this recidivist legislation.

For many years DV batterer treatment was the most common, and sometimes only, legal response in DV cases. There was growing concern by many practitioners about this "one size fits all" approach for DV misdemeanors, felonies, family law, and all manner and type of DV perpetrators placed for treatment. In 2012, an unusual coalition of the Washington Association of Prosecuting Attorneys and Washington Association of Criminal Defense Lawyers joined to support legislation to direct the Washington State Institute for Public Policy (WSIPP) to update its analysis of the scientific literature on domestic violence (DV) treatment under HB 2363 (2012). After the bill passed, WSIPP

delivered its findings to the legislature on DV batterer treatment in 2013, generating local and national impact.[9]

The WSIPP report came in a wave of reports from Federal, State, and local institutions highlighting concerns with the efficacy of batterer treatment.[10] The WSIPP report made the primary finding that "Duluth-like" treatment for batterers was ineffective.[11] The local and national DV treatment community pushed back, pointing

[9] *See* Miller, M., Drake, E., & Nafziger, M. "What works to reduce recidivism by domestic violence offenders?" (Document No. 13-01-1201). Olympia: Washington State Institute for Public Policy (2013); Drake, E., Harmon, L., & Miller, M. "Recidivism Trends of Domestic Violence Offenders in Washington State." (Document No. 13- 08-1201). Olympia: Washington State Institute for Public Policy (2013). The work on domestic violence to date is the most frequently downloaded report on WSIPP's web site.

[10] *See* Gill, Lum, "Evidence Based Assessment of the City of Seattle's Crime Prevention Programs," George Mason University, Center for Evidence Based Crime Policy (2012) **"**the programs showed no effect on victim reports of further violence."; Office of Justice Programs, National Institute of Justice web page on Batterer Intervention, Available at https://www.nij.gov/topics/crime/intimate-partner-violence/interventions/pages/batterer-intervention.aspx "Most findings show that these programs do not change batterers' attitudes toward women or domestic violence, and that they have little to no impact on reoffending."; NPR Marketplace, "Mad Men to Math Men", July 29, 2013 on Iowa Department of Corrections; "Addressing Family Violence In Connecticut: Strategies, Tactics, and Policies" (Legislative report to the Connecticut Public Health Committee), Available at http://www.ctcase.org/reports/family_violence.pdf; "Why Domestic Violence Prevention Programs Don't Work," May 23, 2014, NBC News, Available at https://www.nbcnews.com/storyline/nfl-controversy/why-domestic-violence-prevention-programs-dont-work-n217346; Babcock, J.C., Green, C.E., Robie, C., "Does batterers' treatment work? A meta-analytic review of domestic violence treatment." Clinical Psychology Review 23 1023–1053 (2004); Cluss, P. & Bodea, A. "Effectiveness of Batterer Interventions: A Literature Review and Recommendations for Next Steps." University of Pittsburg (2011); Feder, L., Wilson, D., "A meta-analytic review of court-mandated batterer intervention programs: Can courts affect abusers' behavior?" Journal of Experimental Criminology 1: 239–262 (2005); Smedslund G, Dalsbø TK, Steiro A, Winsvold A, Clench-Aas J. "Cognitive behavioural therapy for men who physically abuse their female partner." Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No. CD006048. DOI: 10.1002/14651858.CD006048.pub2.

[11] WSIPP identified programs as Duluth-like if the study authors indicated the programs were based on the Duluth curriculum or the articles stated the interventions focused on male privilege, power and control, and gender stereotypes. Of the seven studies of programs categorized as Duluth-like, all but one explicitly indicated the program was based on the Duluth curriculum.

out the limitations of the meta-analysis[12], and demanded a look at the whole system, not just individual parts.

The WSIPP report and conflicting arguments from the treatment community left courts confused and with seemingly few options. Courts need tools to respond to the large number of criminal domestic violence cases (over 30,0000 charged cases every year since 2001),[13] civil protection orders, and family law matters. Moreover, the Department of Corrections caseload of domestic violence offenders expanded as they were directed by the legislature under SB 5070 and RCW 9.94A.501(4)(e)(ii) to supervise DV felons no matter their risk level.[14] A new approach was needed to find ways to reduce recidivism by domestic violence offenders, provide both victims and offenders with meaningful answers about what works, and close critical safety gaps.

There is no easy answer to what works to reduce DV recidivism, and HB 1163 reflects the uncertainty in how best to respond and treat DV offenders. Pursuant to HB 1163, Section 7, the Legislature established the Washington Domestic Violence Perpetrator Treatment Work Group (PTWG) "to address the issue of domestic violence

[12] It is a common misconception that all programs in Washington follow "the Duluth model." First, the Duluth *model* refers not to a treatment modality, but rather to the systemic community response to domestic violence. The Duluth *curriculum* is an approach to addressing domestic violence that attempts to identify and change the patterns of thinking that precipitate and perpetuate abusive behavior. The Northwest Association of Domestic Violence Treatment Professionals (NWADVTP) conducted a statewide survey of DSHS-certified programs in 2014. At that time, there were approximately 105 such programs and the survey received responses from 67 of them. Out of the responding programs, only four identified that they utilized the Duluth curriculum as their primary modality. Therefore, the overwhelming majority of programs do not utilize a Duluth curriculum.

[13] "Recidivism Trends of Domestic Violence Offenders in Washington State." (Document No. 13- 08-1201). Olympia: Washington State Institute for Public Policy.

[14] In prior years the Department of Corrections provided limited supervision of DV offenders, as only those who qualified as "high violent" and eligible by crime type for monitoring were supervised.

perpetrator treatment and the role of certified perpetrator treatment programs in holding domestic violence perpetrators accountable."[15] The work of this Section 7 work group complements and overlaps with the work of the work group established in HB 1163 Section 8, tasked with studying "how and when risk assessment can best be used to improve the response to domestic violence offenders and victims and find effective strategies to reduce domestic violence homicides, serious injuries, and recidivism that are a result of domestic violence incidents in Washington state."

Work Group Convener: The Washington State Supreme Court Gender and Justice Commission

HB 1163 states that "[t]he administrative office of the courts shall, through the Washington state gender and justice commission of the supreme court, convene a work group to address the issue of domestic violence perpetrator treatment and the role of certified perpetrator treatment programs in holding domestic violence perpetrators accountable." This legislative work group was co-chaired by Judge Eric Lucas of Snohomish County Superior Court and Judge Marilyn Paja of Kitsap County District Court on behalf of the Washington State Supreme Court Gender and Justice Commission.

In 1987, the Washington State Legislature tasked the Administrative Office of the Courts with developing measures to prevent gender bias in the state court system. After two years of research, public hearings, and surveys, the Gender and Justice Task Force

[15] ESSHB 1163, 2017 Leg., 65th Leg., Reg. Sess. (Wa. 2017).

concluded that gender bias existed in the Washington State court system and described the extent of that bias along with recommendations for change in its final report, *Gender and Justice in the Courts*, *Washington State,* 1989.

The Washington State Gender and Justice Commission was established by the Washington Supreme Court in 1994 to continue the job of monitoring and implementing the recommendations from the report. The Court has renewed the Commission every five years since, most recently in 2015. The purpose of the Commission is to identify concerns and make recommendations regarding the equal treatment of all parties, attorneys, and court employees in the State courts, and to promote gender equality through researching, recommending, and supporting the implementation of best practices; providing educational programs that enhance equal treatment of all parties; and serving as a liaison between the courts and other organizations in working toward communities free of bias.

Work Group Designees and Other Contributors:

The following work group members were statutorily designated:

- Superior Court Judges: Judge Kristin Richardson (King County Superior Court)
- District Court Judges: Judge David Steiner (King County District Court)
- Municipal Court Judges: Judge John Curry (Orting Municipal Court)
- Court Probation Officers: Bree Breza (Airway Heights Municipal Court & Probation)

- Prosecuting Attorneys: David Martin (Washington Association of Prosecuting Attorneys/King County Prosecuting Attorney's Office)

- Defense Attorneys: Alex Frix (Washington Defender Association/Thurston County Public Defense); Sophia Byrd McSherry, Deputy Director (Washington State Office of Public Defense)

- Civil Legal Aid Attorneys: M. Abbas Rizvi (Northwest Justice Project)

- Domestic Violence Victim Advocates: Jake Fawcett and Tamaso Johnson (Washington State Coalition Against Domestic Violence)

- Domestic Violence Perpetrator Treatment Providers: Keith Waterland, LICSW (Anger Control Treatment & Therapies); Mark Adams, MA, LMHC (Wellspring Family Services)

- Department of Social and Health Services: Amie Roberts

- Department of Corrections: Dr. Karie Rainer

- Washington State Institute for Public Policy: Dr. Marna Miller

- University of Washington Evidence-Based Practice Institute: Lucy Berliner

Other contributors invited to the work group included:

- Brett Ballew (Washington State Office of Public Defense)

- Commissioner Kathleen Kler (Jefferson County)

- David Baker (King County Prosecuting Attorney's Office)

- Grace Huang (Asian Pacific Institute on Gender-Based Violence)

- Jennifer Creighton (Thurston County District Court)

- Judge Adam Eisenberg (Seattle Municipal Court)

- Koa Lee (Pierce County District Court Probation)

- LaTricia Kinlow (Tukwila Municipal Court)
- Mindy Breiner (Tukwila Municipal Court)
- Omar Gamez (Edmonds Municipal Court)
- Randy Kempf (Chehalis Tribe)
- Stephanie Condon (Department of Social and Health Services)
- Trese Todd (Domestic and Gun Violence Survivor Volunteer)

Staff from the Administrative Office of the Courts who coordinated, facilitated, and provided other administrative support to this work group included Cynthia Delostrinos, Kelley Amburgey-Richardson, Nichole Kloepfer, and contract staff Laura Jones.

Work Group Activities

Throughout the course of this work group, four in-person work group meetings were held:

- **October 4, 2017**: Introductions of co-collaborators, key stakeholders, and participants; discussion of questions posed by legislature; issues identified; tentative work plan established
- **December 12, 2017**: System mapping; presentations about Seattle Municipal Court's DV Intervention Program (DVIP) pilot project and revisions to Chapter 388-60A WAC; work plan further developed
- **February 27, 2018**: Presentations by DSHS and WSIPP regarding evidence-based treatment and discussion of treatment modalities

- **May 8, 2018**: Update on Seattle Municipal Court's DVIP Pilot; discussion regarding draft report and proposed recommendations; areas requiring additional information identified

Additionally, the work group communicated via list serve, created a shared drive for articles and research, and held monthly work group conference calls in November, December, January, February, April, May, and June. Topics addressed on these calls included system mapping, treatment modalities, system response, information sharing, and financing.

ACRONYM GLOSSARY

This section identifies acronyms contained within this report:

CBT	Cognitive Behavioral Therapy
DOSA	Drug Offender Sentencing Alternative
DSHS	Department of Social and Health Services
DV	Domestic Violence
DVIP	Domestic Violence Intervention Program
DVPT	Domestic Violence Perpetrator Treatment
DVOSA	Domestic Violence Offender Sentencing Alternative
ISR	Integrated System Response
MDT	Multi-Disciplinary Team
MRT	Moral Reconation Therapy
PTWG	Perpetrator Treatment Work Group

SOC	Stipulated Order of Continuance
SSOSA	Special Sex Offender Sentencing Alternative
WAC	Washington Administrative Code
WSIPP	Washington State Institute for Public Policy

CONSENSUS

The efforts of this group have been divided into "work product" and "recommendations." The work product details the actual thought and work process we pursued to reach a specific set of recommendations. In this section we seek to provide a complete record of what was considered, and whether there was complete agreement or not. The details of the discussion are important and nuanced.

Consensus has been achieved by the work group with regard to the primary six recommendations listed in the Executive Summary. With regard to the more detailed recommendations summarized at the conclusion of this report, consensus has largely been achieved, although we have experienced some professional differences regarding the details of methodology and/or implementation.

It is our view that this type of report need leave nothing out. We have embraced all views. We attempt to provide a clear picture of the vagaries of the process that produced the final set of recommendations.

SECTION 7 GROUP WORK PRODUCT

Existing Laws and Regulations

The present statutory and regulatory scheme governing Washington's current perpetrator treatment system may be found at Chapter 26.50 RCW and Chapter 388-60 WAC. The current system is often described as "one size fits all." This has been the approach for decades, and this approach has been critiqued by local advocates and system actors.[16] There is a systemic loss of confidence in domestic violence treatment as a meaningful intervention by many stakeholders to the system, including the courts. In large part, the reason for the loss of faith rests on the issue of "evidence-based" treatment. The current statutory and regulatory scheme does not require evidence-based treatment. As such, these governing regulations stand in need of revision.

Evidence-Based Treatment

An "evidence-based program" is one where research evidence from more than one study indicates the program is likely to cause desired outcomes. A survey of the literature and studies regarding evidence-based treatment specific to treating domestic violence offenders indicates that the research is inconclusive and ongoing.[17] The

[16] See e.g. "South King County Domestic Violence Safety and Accountability Audit" (January 2009).
[17] See e.g. Ferraro, Kathleen J., "Current Research on Batter Intervention Programs and Implications for Policy (2017); Zarling and Berta, "An Acceptance and Commitment Therapy Approach for Partner Aggression" (2017); Gove and Richards, "A Review of State Standards for Batterer Intervention Treatment Programs and the Colorado Model" (2017); Babock et al, "Domestic Violence Perpetrator Programs: A Proposal for Evidence-Based Standards in the United States" (2016); Radatz and Wright, "Integrating the Principles of Effective Intervention into Batterer Intervention Programming: The Case for

Washington State Institute for Public Policy's (WSIPP) 2013 report[18] supports this assertion through additional findings that a handful of other approaches (e.g. CBT) appear promising; more research on domestic violence-specific approaches is needed; and interventions shown to reduce recidivism for the general offender population may also be effective for DV offenders.

Revisions to Chapter 388-60 WAC

When adopted on June 29, 2018, revisions to Chapter 388-60 WAC will seek to expand the impact of cognitive behavioral therapy throughout the state. This change is consistent with what works from a clinical-therapeutic approach and reported WSIPP research.

In December of 2015, the Department of Social and Health Services (DSHS) was able to provide full-time funding for the domestic violence perpetrator treatment (DVPT) program manager position. Previously, the position had only been funded part-time. The new full-time allotment allowed the department to expand the job duties of that position.

Chapter 388-60 of the Washington Administrative Code, that creates DVPT program standards, had not been revised since 2001. The new DVPT program manager received input that these standards were outdated from staff at DSHS, as well as several

Moving Toward More Evidence-Based Programming" (2015); Gondolf, "The Weak Evidence for Batterer Program Alternatives" (2011).

[18] Miller, M., Drake, E., & Nafziger, M. "What works to reduce recidivism by domestic violence offenders?" (Document No. 13-01-1201). Olympia: Washington State Institute for Public Policy (2013)

stakeholders. She responded by starting regular DVPT program reviews for WAC compliance and conducting investigations. She also reconvened the long-dormant DVPT advisory committee (as outlined in WAC 388-60). They held their first meeting in June of 2016.

The DSHS DVPT program manager served as the facilitator and chair of the DVPT advisory committee, which also included:

- commissioners,
- judges,
- a representative from the Washington State Coalition Against Domestic Violence,
- a representative from Administrative Office of the Courts,
- victim services representatives,
- DVPT providers,
- probation officers,
- a DV survivor, and
- a representative from the Department of Corrections.

The advisory committee met quarterly and addressed each section of WAC 388-60 to give input for revisions. Members of the advisory committee researched standards from other states, drew on their own expertise and experience, and gathered input from their respective communities to share with the committee.

The WSIPP meta-analysis and the conclusion that the current WAC standards were outdated revealed that DVPT treatment throughout the state was on an unsustainable course. In many jurisdictions, confidence in treatment was faltering. As a result, referrals to DVPT treatment programs over the last several years were reported to be falling drastically. Accordingly, the number of certified providers had been steadily decreasing.

The DVPT program manager gathered information from the department, the advisory committee and national experts in domestic violence to draft revisions to the DVPT program standards. As program reviews and investigations were conducted, the DVPT program manager also gathered critical input from certified programs and victim services agencies throughout the state.

The proposed changes were so significant that the department advised a complete repeal of WAC 388-60 and a replacement with new standards (388-60A). The primary problems that needed to be addressed with the new DVPT standards were:

- A lack of confidence in the efficacy of DVPT treatment, due in part to a lack of outcome data;
- Inconsistent assessments and treatment throughout the state; and
- The perception of a "one size fits all" approach to treatment.

The revised Chapter 388-60A WAC addresses the issues above in the following ways:

Identified problem	Proposed WAC revisions to address the problem
1. A lack of confidence in the efficacy of DVPT treatment, due in part to a lack of outcome data	The draft WAC 388-60A has a new **'quality management' section (388-60A-0125)** that outlines standards for: • Submitting confidential treatment outcome data to the department on a quarterly basis, which will be aggregated and shared with the programs to improve treatment; • Documentation of the program's evidence-based or promising practices they use in treatment; • Documentation of direct observation of groups by the program's supervisor at least every six months; • Documentation of a review of assessments and participant's records for compliance with the WAC and the program's policies and procedures by the supervisor at least every six months; • Documentation of a review of the program's cultural competency at least once a year; • Documentation of how the program will serve participants who require sign language or interpretation; • Documentation of the program's participation and attendance in a local DV task force, intervention committee or workgroup in their area; and • Documentation of how the program collaborates with at least one other certified DVIT program for confidential case staffing, collaboration in the delivery of DVIT services and procedures for victim safety.
2. Inconsistent assessments and treatment throughout the state	The draft WAC 388-60A has significantly more robust standards for **behavioral assessments and interviews (388-60A-0400)** and areas of focus for treatment called **'required cognitive and behavioral changes' (388-60A-0415)** ***The assessment must include:*** • General assessment information; • Seven domains (an assessment of high risk factors, a screening for traumatic brain injury, a screening for mental health factors, an assessment of the participant's belief system, a screening for substance use, an assessment of the participant's environmental factors and an assessment of evidence-based testing for risk, lethality, needs, and psychopathy when indicated); • Acute or critical factors; and • A summary section that includes a summary of the participant's social and legal history, degree of abusive cognitive and behavioral patterns, behaviors that need to

	be targeted in treatment, level of accountability, motivations and readiness to change, results of all evidence-based, empirical and objective standardized tests, the program's recommended level of treatment for the participant, the rationale for that recommendation, and the recommended or required referrals for ancillary services, such as mental health or substance use treatments. ***The required cognitive and behavioral changes include:*** • Acknowledging the types of abuse they have perpetrated; • Individual and cultural belief systems that have supported or allowed domestic violence; • New skills for building respectful relationships including affirmative consent and respecting boundaries; • How children have been affected by the participant's abuse and the long-term consequences of exposure to DV; • Accountability: the ability to be accountable for specific abusive behaviors and the ability to demonstrate spontaneous accountability in treatment; • Why it is necessary to meet financial and legal obligations to family members and the actions they are taking to do so; • Skills to build and increase empathy; • Defense mechanisms and healthy coping strategies to deal with unpleasant feelings; • Self-care as an essential element in healthy relationships; • The participant's support system; • How the indicators the participant has used are abusive; • The cognitive distortions the participant has used to justify their abusive behaviors; • The participant's personal motivations to abuse and what has replaced those beliefs; • An accountable documentation of the participant's relationship history including common characteristics, motivations for abuse, cognitive distortions and indicators of domestic violence; • How the program and participant address the participant's criminogenic needs; and • Other exercises, assignments or processes that address the individual needs of the participant.

	These changes along with new completion criteria and core competencies are expected to make assessments and treatment much more consistent across the entire state.
3. The perception of a "one size fits all" approach to treatment	The draft WAC 388-60A has new **levels of treatment and placement criteria (WAC 388-60A-0410).** • Level 1 (low risk) early intervention, minimum of 6 months, no previous DV charges, and low risk for lethality and recidivism. • Level 2 (med risk) minimum of 9 months, an established pattern of abuse and control, little or no criminogenic needs and medium risk for lethality and recidivism. • Level 3 (high risk) minimum of 12 months, acute or critical assessment factors, identified antisocial traits, criminogenic needs and a high risk of lethality or recidivism. • Level 4 is a minimum of 18 months, participants score medium to high on a psychopathy assessment, are considered high risk and this group must be kept separate from other levels of treatment. This level requires the facilitator to be a 'supervisor' and complete specialized training and continuing education. This group has different focuses of treatment as well (WAC 388-60A-0415). Levels 1-3 have the same areas of treatment focus and required cognitive and behavioral changes. Depending on the degree of the abusive cognitive and behavioral patterns (documented at assessment and throughout treatment), participants need more or less time to make the required changes. The programs must individualize treatment for participants, and they have the ability to move participants into a different level of care and make adjustments to their treatment plans as needed.

Work Group Recommendations re: Evidence-Based DV Treatment

- The Work Group recommends embracing the adoption of the revised Chapter 388-60A WAC because it implements core competencies grounded in cognitive behavioral approaches that are evidence-based and shown to reduce recidivism

in the general offender population.[19] This is consistent with the reported findings and recommendations of the 2013 WSIPP research. Moreover, the revised WAC shifts the emphasis in determining regulatory compliance from mere delivery of services to measuring and documenting the achievement of behavioral outcomes.

However, even though we are hopeful that this new system will work to reduce recidivism, at the current moment we have no proof that it will do so. As such, it is imperative that we evaluate this system via a structure of on-going research in order to verify that the system does work. This is discussed in the following section.

Court and Agency Practices

Ongoing Evaluation to Assess Efficacy and Make Quality Improvements

Definition of Domestic Violence

Systemically, there are both legal and behavioral definitions of domestic violence that delineate the behaviors which constitute acts of domestic violence and describe the relationship between the parties. However, there are significant differences between the

[19] Please refer to Appendix C to this report for an example of how an outcomes requirement to demonstrate individualized cognitive and behavioral changes can be documented. These are the kind of changes that cognitive behavioral therapy (CBT) models would argue produce the ultimate reduction in recidivism.

two definitions. Washington State's legal definition of domestic violence conduct is narrower than the behavioral definition. [20] But, its relational context is much broader.[21]

For multiple reasons, Washington's definition of domestic violence as a narrow range of behavior applied across a wide range of relationships directly impacts domestic violence perpetrator treatment. Sometimes this impact is negative in nature.

First, the recommendation or order of an individual into DV treatment based upon the broad relational definition can lead to individuals with significantly different needs being placed into the same treatment program. For example, a person might be referred for an act of intimate partner violence and end up in the same group with an individual who assaulted a non-intimate roommate, or perhaps, a sibling. Those individuals would have significantly different treatment needs. Moreover, Chapter 388-60 WAC[22] is intended to be applied to situations involving intimate partner domestic violence.

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[20] In RCW 26.50.010, Washington's legal definition of domestic violence conduct is limited to the following: "(a) physical harm, bodily injury, assault, or the infliction… of fear of imminent physical harm, bodily injury or assault… (b) sexual assault … (c) stalking" whereas the behavioral definition defines domestic violence conduct more broadly as a "pattern of assaultive and coercive behaviors" … "including physical, sexual, and psychological attacks, as well as economic coercion." Domestic Violence Bench Guide for Judicial Officers (Rev. 2015), Chapter 2, p. 2-4. The current federal definition of domestic violence and how domestic violence is referred to in Chapter 388-60 WAC are much more similar to the behavioral definition than to Washington's legal definition.

[21] In RCW 26.50.010(6), Washington broadly defines "family or household member" to include "spouses, former spouses, persons who have a child in common regardless of whether they have been married or have lived together at any time, adult persons related by blood or marriage, adult persons who are presently residing together or who have resided together in the past, persons sixteen years of age or older who are presently residing together or who have resided together in the past and who have or have had a dating relationship, persons sixteen years of age or older with whom a respondent sixteen years of age or older has or has had a dating relationship, and persons who have a biological or legal parent-child relationship, including stepparents and stepchildren and grandparents and grandchildren."

[22] See discussion in the preceding section of this report regarding the current process to significantly revise WAC 388-60.

Second, the broader behavioral definition has led to an inability to capture data specifically related to intimate partner domestic violence. This data deficit prevents study needed to promote quality control and improvement. Currently, data collected by the Administrative Office of the Courts tracks cases with a Domestic Violence "designation." However, this designation includes all types of relationship under the broad definition, and the data for intimate partner cases and non-intimate partner cases cannot be separated. This makes it difficult for researchers to evaluate Washington data in order to assess the efficacy of treatment.

A legislative amendment that refines the definition of Domestic Violence would best address these issues. This work group does not advocate for a substantive change to the definition, but rather a bifurcation into two different categories of relationships: intimate partner and the broader family or household relationship. This technical change will not impact the relief available to parties based on the category of their relationship. This recommendation is also being made by the HB 1163 Section 8 DV Risk Assessment Work Group.

Additional Data Collection Fields

Responsible management practices require evaluation of program performance and improvement through ongoing data collection, research, analysis, and reporting.[23] Further, providing adequate feedback to courts and justice system partners is critical.

[23] Since 1991, the legislature has recognized that further study is needed to determine efficacy of treatment: "Much has been learned about effective interventions in domestic violence situations; however, much is not yet known and further study is required to know how to best stop this violence." RCW 10.99.020 [1991 c 301 § 1.]

Such feedback will be more effective if leaders, managers, and line staff share a commitment to seeking adaptations and innovations that can gradually improve performance over the long-term.

Academic researchers on our work group agree that data must be collected about treatment to assess its efficacy following the implementation of the revised WAC and must include:

- Whether treatment was ordered;
- Level of treatment and any change during the course of treatment;
- Modality of treatment and any change during the course of treatment;
- Whether treatment was completed;
- Recidivism post-treatment including the commission of new DV crimes*;
- The commission of other crimes with a weapon or other violent crimes*; and,
- The commission of other general crimes*.

In order to support better collection of data in criminal cases (as well as to promote compliance with court orders),[24] the legislature should mandate a five-year probation period for offenders convicted of intimate partner domestic violence. RCW 3.66.068(1)(a) gives the court continuing jurisdiction over domestic violence cases for up to five years. However, this is not uniformly applied across the state and levels of

* This recidivism data may already be available from other sources.

[24] For further discussion on how a five-year probation period affects compliance refer to report section: Ensuring Compliance with Court-Ordered Treatment.

courts. In addition to requiring a five-year probation period for intimate partner domestic violence offenses, this statute should be amended to require active[25] probation until treatment is completed, changing to inactive probation[26] for the duration of the five-year period to aid monitoring and data collection.

Improved supervision of DV offenders should be considered along with requiring specialized supervision from Washington Department of Corrections and training of misdemeanor probation officers. We realize that expansion of probation may raise potential cost issues. However, the legislature recently required supervision for DV felonies and certain DV misdemeanors. Work Group members raised concerns that many cities may be unable to meet the financial commitment of five years of active probation. Accordingly, the Work Group has developed a recommendation that distinguishes between "active" and "inactive" probation to help mitigate this expense, as discussed above.

We recognize that mandated supervision may also result in exposure to civil liability if there is a failure to appropriately supervise.[27] At minimum, this risk could be addressed with proper training. However, there may also need to be legislatively

[25] Required to meet with probation officer on a regular basis.
[26] Does not require meeting with a probation officer. Essentially, court monitoring of the case. Many probation departments use the following scheme: 1) Supervised probation (our active); 2) Monitored Probation (one service/task, very short term) and 3) Records check. Our view is that "inactive" probation embraces descriptors 2 and 3.
[27] See claim for damage for failure to supervise at https://www.seattletimes.com/seattle-news/crime/failure-to-supervise-parolee-led-to-renton-womans-slaying-her-father-alleges/; see also recent liability of $13 million for Seattle Municipal Court for failing to supervise repeat drunk driver https://www.seattletimes.com/seattle-news/city-of-seattle-and-family-of-relatives-killed-by-repeat-drunken-driver-settle-lawsuit-for-13-million/

implemented alternative forms of claim relief.[28] Again, our motivation for expanded probation is two-fold: 1) completion of treatment, and 2) gathering of essential information related to the efficacy of treatment during the five-year period. This is not an evidence-based recommendation and it needs to be subjected to rigorous evaluation.

Within the context of civil cases, a calendar review model such as the one discussed in the following section of this report, could also support the goals of completion of treatment and gathering of information related to efficacy of treatment.

Outcome Evaluation

The new Chapter 388-60A WAC is not a stand-alone solution to the problem of domestic violence in Washington. Although the new WAC seeks to implement the current view of what constitutes best practices, the research surrounding many of these recommendations is either thin or non-existent. For example, the four-tiered approach proposed by the WAC is based on a model developed in Colorado[29] that has not been "rigorously" evaluated. There is currently no evidence that the tiered approach reduces recidivism more than the single program model. The programs will likely be delivered using a variety counseling approaches and will occur in a range of different community and legal contexts.

As stated, our goal is to have a system-wide implementation of evidence-based practices. After consideration, the best response, as we see the problem, is to fund and

[28] Members of the group have commented that it is foreseeable that this could be relieved by tort reform.
[29] http://www.bwjp.org/resource-center/resource-results/colorado-dv-offender-treatment.html

direct our own research entities[30] to provide the systemic scientific evidence that is required. Implementation of the new WAC represents a unique and significant opportunity to rigorously evaluate the effects of the four-tiered treatment model. At minimum, the study should determine its effects on criminal recidivism. To the extent possible, the study should also measure the effect of the various treatment approaches identified in the data repositories and the extent to which the local systems are utilizing an Integrated System Response.

Such an evaluation may take several years to have results but there is no quick fix which will repair the loss of confidence in DV treatment. Our view is to embrace a long-term approach grounded in science, evaluation, and evidence-based practice. Based on the findings of this evaluation, it is our hope that the legislature or DSHS would consider changes to the RCW or WAC regarding DV treatment.

Work Group Recommendations re: Ongoing Evaluation:

- **WAC Compliance and Enforcement:** DSHS needs to be adequately staffed in order to: 1) train programs statewide regarding the new WAC standards, and 2) to effectuate and ensure continuing program compliance with the new WAC regulations.

[30] Research entities at minimum means: Washington State Institute for Public Policy (WSIPP), Washington State Center for Court Research (WSCCR), University of Washington's Evidence Based Practice Institute, and Washington State University. Research assignments and protocols should be designed to remove any potential conflicts of interest and all research should be peer-reviewed.

- **Ongoing Evaluation:**
  - Adequate, ongoing, and multi-year funding is needed for statewide monitoring, research and evaluation, to assess the efficacy of DV perpetrator treatment post-implementation of the new WAC. In particular, we recommend that the legislature fund a rigorous outcome evaluation of the effects of the new WAC on recidivism. While current research suggests that CBT approaches are effective, no studies have actually been done on programs in Washington State.
  - Another suggestion to ensure the completion of treatment, compliance with sentences, and the collection of necessary data for ongoing evaluation would be to impose a mandatory five-year probation period for criminal cases involving domestic violence offenses committed against an intimate partner, with active probation until treatment is completed, then inactive probation for the duration of the five-year period. Within the context of civil cases, a calendar review model could support the goals of completion of treatment and data collection.
  - The legislature should refine Washington's definition of Domestic Violence to distinguish between intimate partner violence and other categories of domestic violence. This will likely promote more effective treatment by ensuring referral into appropriate treatment programs, as well as enabling the collection of data to better evaluate the efficacy of treatment for perpetrators of intimate partner violence.

- Include the following additional data fields to be tracked by the Administrative Office of the Courts court for further evaluation of DV treatment: whether treatment was ordered; level of treatment and any change during the course of treatment; modality of treatment and any change during the course of treatment; and whether treatment was completed.

System Response: Decrease Recidivism

Treatment programs are not intended to be a stand-alone intervention. They are dependent on other aspects of the system in order to work effectively. Domestic violence is a complex issue, with several "human factors," which encompass more than what research data alone has been able to tell us. For example, studies conducted at treatment sites in Chicago, California, Pittsburg, and Denver, importantly find that "[a]fter controlling for other background characteristics, by far the strongest predictor of re-assault at any of the four sites was dropping out of the program."[31]

The Integrated System Response (ISR) approach for which this Work Group advocates explores how the system can help to support DV treatment. In the following sections, we explore how the sharing of quality information, promoting treatment accessibility through reliable funding sources, and increased access to training and

[31] Gondolf, Edward W. The Future of Batterer Programs: Reassessing Evidence-Based Practice. Northeastern University Press (2012).

resources for professionals working in the field could help to promote an effective ISR and reduce recidivism.

Sharing of Information

DV perpetrator treatment cannot exist in a vacuum. There must be information-sharing between the treatment provider and the system throughout the course of treatment to maximize its efficacy. Initially a quality assessment is predicated on having good information. For example, ensuring that the assessor has access to prior reports, victim information, and criminal history. As court-ordered treatment progresses, ongoing system oversight (whether through multi-disciplinary teams, review hearings, or supervision by probation) is essential to promoting consistency, compliance, and victim safety.

Assessment: Analysis of the need for a Universal Diagnostic Tool

Some systemic observers believe that inconsistencies in assessment and treatment can be eliminated by utilization of a high-quality universal diagnostic tool. Clearly, system-wide use of the same tool will create formal uniformity. However, both the contributors to the WAC Advisory Committee and many members of our Section 7 Work Group strongly asserted that this approach would not solve the problem. Indeed, the new WAC does not mandate it.

The Work Group found that emphasis on a universal diagnostic tool for DV perpetrator treatment is not essential. What is of critical import in the task of assessment

and diagnosis is the quality of information on which assessment and diagnosis is based. Quality of information is an Integrated System Response (ISR) problem; assessment and diagnosis are placed at risk if the quality of the information is suspect. If the sources of the information utilized are omitted, distorted, corrupted or biased, the resulting assessment and diagnosis, and therefore the effectiveness of treatment, will not be reliable. Quality information at the assessment phase will also help to better identify individuals for whom treatment is appropriate.[32]

The information necessary for reliable assessment and diagnosis comes from:

- mental health history;
- substance abuse history;
- criminal history;
- police information systems;
- judicial information systems;
- prior assessment records whether risk or diagnosis;
- prior treatment records;
- probation records;
- department of correction records; and most importantly
- victim reports.

[32] This is an issue with the dependency process where casting a wide net for possible perpetrators means that many people who do not need DV treatment are required to engage anyway. This delays permanency for children, strains limited resources, and erodes confidence in the system.

These information sources must be effectively integrated **in a statewide system** in order to ensure the effectiveness of assessment, diagnosis, and the subsequent treatment. For example, information regarding treatment completion or failure must be available between jurisdictions to determine the proper level of risk and subsequent treatment.

Our current system defaults to treatment agencies to create this much-needed integration without providing the tools to do so. Treatment agencies do not have universal access to: mental health history; substance abuse history; criminal history; police information systems; judicial information systems; prior assessment records whether risk or diagnosis; prior treatment records; probation records; Department of Corrections records; and victim information. Also, treatment agencies cannot coordinate on a statewide basis. This lack of information hampers their ability to assess and diagnose, which is necessary for effective risk assessment and treatment.

Informational gaps are compelled to be filled by perpetrator self-report, which is not acceptable. A system that compels coercive intervention and treatment must do more to provide the information necessary to accomplish the task.

The realization that this information problem is also "dynamic" and not "static" is extremely important. This means that the information in the system needs to be current. And as information changes and/or updates, it is essential that such new information be incorporated into the intervention process as soon as possible, no matter

the jurisdictional source. Particularly with regard to the problem of lethality, current information is paramount in its importance.[33]

In short, the conceptuality of a universal diagnostic tool should be replaced with concepts that are conversant with the Quality of Information problem. Solutions to the Quality of Information problem will require re-conceptualizing the role of the courts.

As our discussion and analysis focused on this problem, it became increasingly clear that there needed to be a centralized location where this information could be held and "integrated" in order to avoid defaulting this function to treatment agencies. Yet such centralization raised new concerns about the ability of a centralized "information repository" to maintain and effectively distribute information without creating a confidentiality breach for both offenders and victims. Further discussion brought forth a systemic response: Therapeutic Courts.

DV Treatment and Therapeutic Courts

Washington State has a fairly long history of utilizing Therapeutic Courts to deliver treatment in: drug abuse, mental health, and other areas.[34] These courts have developed systems that routinely deal with confidential information and its dissemination among members of a multi-disciplinary group or team. Most often, the

[33] For example, we know that certain factors such as: job loss, a new assault, weapons acquisition, change in marital status, change in child custody, etc., are indicators of increased lethality. This is not an exhaustive list. So, if a person is released from custody on their personal recognizance and then they lose their job or child or acquire a weapon, the case needs to be newly reviewed in order to determine if there has been a change in their level of risk.

[34] Therapeutic Courts in Washington: See Chapter 2.30 RCW

court in question, engages in a process referred to as "staffing." In staffing, the therapeutic information shared by the team in order to deliver effective treatment is confidential. In *State v. Sykes* [35] the Washington State Supreme Court held:

> Adult drug courts are philosophically, functionally, and intentionally different from ordinary criminal courts. Based on their unique characteristics, we hold that adult drug court staffings are not subject to the open courts provision of article I, section 10. Whether adult drug court staffings are presumptively open or closed is left to the discretion of the individual drug courts.[36]

The Work Group agrees that DV Courts should receive similar treatment. Given this legal framework, it became evident that a probable solution to the Quality of Information Problem would be to centralize information collection by creating an information repository housed in the courts, within their probation/community supervision function.[37] This would allow the courts to have access to and broker information necessary to complete their treatment and supervision function. Other entities, for example treatment providers completing an assessment, would be able to rely on the courts as a repository/exchange for information instead of relying on voluntary and ad hoc sharing—just as in staffing referenced above.

However, the Work Group concluded that other, additional, safeguards to confidentiality should also be put in place, in order to balance access to information,

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[35] *State v. Sykes*, 182 Wn.2d 168, 339 P.3d 927 (2014).
[36] *Id.* at 171.
[37] Both District Court and Juvenile Court probation already perform in this manner. Juvenile Court maintains a confidential "social file" which allows for the delivery of various therapeutic services without fear of public disclosure. See RCW 13.50.010.

while protecting confidentiality of victim[38] and defendant information. Given Washington's strong presumption of open courts, the Work Group proposes the following options:

- Court Rule 22 could be amended to include therapeutic courts.[39] Please refer to Appendix D for proposed amendments. These amendments would allow the courts to emulate the long-standing "social file" model that is used in juvenile court throughout the State of Washington.
- In addition, the court should also follow what the Work Group found to be existing best practices, which include redacting assessments and reports submitted to the court by treatment providers.[40] The intent of the redaction is to exclude medical diagnosis and other sensitive information after making a finding pursuant to *Ishikawa/Chen* that the redacted copy satisfies the balance between the public's right to open access to the courts and the defendant's right to privacy.[41] Under this

[38] WSCADV has concerns about victim safety as it relates to privacy and confidentiality of victim records and confidences, and anonymity of victim information is of particular concern for many group members. One way to ensure the confidentiality of this information is to again treat it similarly to offender information in juvenile court. In RCW 13.50.010(12), it states in part: "…The administrative office of the courts shall maintain the confidentiality of all confidential records and shall preserve the anonymity of all persons identified in the research copy. Data contained in the research copy may be shared with other governmental agencies as authorized by state statute, pursuant to data-sharing and research agreements, and consistent with applicable security and confidentiality requirements. The research copy may not be subject to any records retention schedule and must include records destroyed or removed from the judicial information system pursuant to RCW 13.50.270 and 13.50.100(3)." DV victim information could be handled in exactly the same manner.

[39] Therapeutic courts are defined in RCW 2.30.010 and include Domestic Violence Courts.

[40] "Best practices" are not exhaustively listed herein. However, it is generally recognized that treatment providers, and drug and other therapeutic courts utilize "contracts" and "releases" to address problems of confidentiality.

[41] The analysis as to what portions of a report to redact would need to be individualized pursuant to *Seattle Times v. Ishikawa*, 97 Wn.2d 30, 640 P.2d 716 (1982) and *State v. Chen*, 178 Wn.2d 350, 309 P.3d 410 (2013).

approach, the redacted copy would become a part of the public court file and the original un-redacted report is deemed "quasi-private" and would only be available for review by the judge, prosecution, and defense. Here again, we have the "public file vs. social file," distinction.

In the DV context, unlike the Drug Court model, the Work Group has identified at least three different structures under which DV Therapeutic Courts could operate: Multi-Disciplinary Team; Probation/Supervision, and "DOSA[42]-like" Calendar Review. The reason for this approach is the need to deliver these therapeutic services in distinctly different jurisdictional environments. In other words, just like there cannot be a "one size fits all" treatment regime, there cannot be a "one size fits all" DV Court structure. Each jurisdiction requires the flexibility to select the best DV Court format to fit its needs. Each structure will be discussed briefly below.

Multi-Disciplinary Teams (MDTs): The MDT is the closest in structure to the traditional drug court. It is another solution to the Quality Information Problem. This team would ideally consist of treatment providers, probation counselors, and victim advocates, as well as defense social workers, mental health counselors, and chemical dependency counselors, when appropriate. The MDT would meet regularly in person or by phone to discuss a defendant's progress in treatment. An excellent example of this format is found in the City of Seattle. Seattle is currently piloting a Domestic Violence Intervention Project (DVIP) whose core is the MDT component (See Appendix

[42] Drug Offender Sentencing Alternative

E). The Work Group is excited about the prospects of this pilot and hopefully it will serve as a statewide model. In smaller jurisdictions, or those with more limited resources, the MDT model may be able to be adapted.[43]

Probation/Supervision: The probation model is most closely aligned with current District and Municipal Court operations. In this model the "team" is limited in most cases to the Probation Officer and the treatment agency. And in some cases, the Probation Officer delivers the treatment. However, the need to centralize, share and update information remains the same. Our Work Group membership included individuals from smaller jurisdictions who view the MDT model as too large and too expensive: both from a governmental expenditure side and from the perpetrator side.

Smaller courts have utilized DV Moral Reconation Therapy (MRT) programs in order to meet the needs of their defendants. These low-cost programs enable the court to deliver DV treatment where otherwise the defendants could not afford it. The DSHS DVPT program manager and the Work Group have been in continual communication with these courts to ensure our proposals meet the need of these jurisdictions. We want to ensure that proposals are workable and enable them to be in compliance with all aspects of the newly proposed WAC regulations. Like all treatment models, adequate assessment of success needs to occur over time.

[43] For example, if there is only one DV treatment provider, the MDT will consist of that provider plus one outside consulting agency as required under the new Chapter 388-60A WAC; or, if there is no probation department, the court could bench monitor treatment progress.

Calendar Review: Superior Courts routinely supervise the alternative sentences referred to as "DOSA" (Drug Offender Sentencing Alternative). Courts can accomplish this in many creative ways. For example, in Snohomish County, where there are fifteen Superior Court Judges, one judge oversees the "DOSA" calendar—even though that judge did not impose the myriad of DOSA sentences. The DOSA judge supervises all DOSA sentences for the entire bench.

It is easily conceivable that all DV sentences and/or orders could be consolidated into one DV Treatment Review calendar, where appropriate. **This is an extremely significant idea.** The reason it has such significance is that a DV calendar of this type would enable the court to review **all cases, criminal and civil, where there has been an order for DV assessment and treatment.** This approach solves the perennial family court problem of requiring the (often pro se) victim to file a contempt motion to enforce the court-ordered DV treatment of the perpetrator. Utilizing this sort of court routine would make all DV treatment court-ordered: whether the original order was criminal, family, or the result of a civil protection order.

All of these activities should come under the auspices of the Therapeutic Court approach.

Advance Treatment Outcomes

Ensuring Compliance with Court-Ordered Treatment

The current system response to noncompliance with treatment is widely divergent. Even within a single court jurisdiction, there may be an inconsistent response. In some cases, a noncompliant offender will immediately be set for a violation hearing where an offender may be given an immediate, meaningful consequence. In other cases, there may be no violation hearing, or no consequence may be imposed. Inconsistent systemic responses to noncompliance undermine accountability. A consistent judicial approach that includes regular reviews, appropriate sanctions, and probation support through the end of treatment, is needed. Some probation departments in the state are terminating probation services before the participant finishes treatment, which essentially has them dropping out of treatment at that point.

As mentioned above, in the civil context, the system response is also problematic. If DV treatment is imposed as part of a family law case, a victim is required to bring a motion for contempt to enforce the court-ordered treatment. In protection order cases, commissioners often order mental health, drug and alcohol, sexual deviancy, and domestic violence assessments at the temporary orders phase. There is an inconsistent response from commissioners when a respondent either does not obtain an evaluation or obtains one from a less reliable provider. This inevitably results in more hearings for the petitioner.

In order to monitor and support compliance with court orders, this Work Group recommends that courts establish a regular DV review calendar for any litigant, whether part of a civil or criminal case, ordered by the court to complete DV perpetrator treatment.[44] The judge presiding over this calendar would be responsible for reviewing whether those individuals were complying with court-ordered treatment. An additional benefit to establishing this process is that attendance by victims would not be required—unlike a contempt motion.

DV Sentencing Alternatives

There are currently no sentencing alternatives for DV crimes; the Drug Offender Sentencing Alternative (DOSA) and Special Sex Offender Sentencing Alternative (SSOSA) do not include a DV treatment response, and there is no "DVOSA." Part of the rationale behind creating sentencing alternatives is to increase victims' willingness to report sexual assault and participate in the criminal justice process,[45] while still holding offenders accountable.[46] These sentencing alternatives allow convicted offenders the opportunity to serve all or part of their sentence out of custody while they participate in a treatment program.[47] Their sentence is suspended pending completion of the treatment program.

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[44] It is envisioned that this review calendar would resemble the review calendar for Drug Offender Sentencing Alternatives (DOSAs). See discussion above.
[45] Victims may have concerns about the consequences to offenders and their family if the crimes are reported (e.g. economic consequences) and want an option other than prison."
[46] Berliner, "Sex Offender Sentencing Options: Views of Child Victims and Their Parents" (2007).
[47] See RCW 9.94A.660, RCW 9.94A.670

Not all offenders convicted of a sex offense are eligible for a SSOSA, nor are all offenders convicted of a drug offense eligible for a DOSA; the governing statutes outline several eligibility requirements. For example, to qualify for a SSOSA, the following criteria must be met:

1. The offender has been convicted of a sex offense other than Rape in the Second degree or a sex offense that is defined by RCW 9.94A.030(46) as a serious violent offense.[48]

2. If the conviction results from a guilty plea, the offender must, as part of the plea of guilty, voluntarily and affirmatively admit that he or she committed all elements of the crime.[49]

3. The offender has no prior sex offense convictions as defined in RCW 9.94A.030 or prior felony sex offenses in this or any other state.[50]

4. The offender has no adult convictions of a violent offense within five years of the date of the current offense.[51]

5. The offense did not result in "substantial bodily harm" to the victim.[52] This means that there is no bodily injury that involves temporary but substantial disfigurement, or that causes a temporary but substantial loss or impairment of the function of any body part or organ, or that causes a fracture of any body part or organ.[53]

6. The offender must have an established relationship with, or connection to, the victim such that the sole connection with the victim was not the commission of the crime.[54]

[48] RCW 9.94A.670(2)(a)
[49] RCW 9.94A.670(2)(a)
[50] RCW 9.94A.670(2)(b)
[51] RCW 9.94A.670(2)(c)
[52] RCW 9.94A.670(2)(d)
[53] RCW 9.94A.670(1)(b)
[54] RCW 9.94A.670(2)(e)

Prior to implementation of a sentencing alternative for domestic violence offenses, similar restrictions should be considered. Furthermore, treatment alternatives should only be authorized in cases where an offender is determined to be amenable to treatment after an assessment by a certified domestic violence treatment provider.

For felony cases, offenders meeting certain criteria may be sentenced to drug offender sentencing alternatives (DOSA). However, currently, when the underlying case involves co-occurring domestic violence and substance abuse, a DOSA excludes any DV interventions and focuses only on substance abuse treatment. A new felony sentencing alternative (DVOSA) could be created to close this gap and address co-occurring domestic violence and substance abuse--for which there are promising approaches.[55] Also, determination of eligibility for such programs (DVOSA) should be directed to Washington Department of Corrections as is done in the case of the current DOSA assessment.

At the misdemeanor level, the primary sentencing alternative is deferred prosecution, which is again only used for substance abuse. Sentencing alternatives or expansion of deferred prosecution is needed for DV misdemeanors. Currently attempts to address the problem are done by a prosecution-led diversion process, not available in every jurisdiction, often referred to as "a stipulated order of continuance" or SOC. Often SOCs operate without effective oversight from the legislature or the court. This use of

[55] *See* pp. 7-8 of WSIPP's 2013 report, "What works to reduce recidivism by domestic violence offenders?" (Document No. 13-01-1201), for promising approaches with DV offenders.

SOCs creates a real "unregulated vs. regulated" system tension.[56] Unregulated approaches create inconsistency in process and treatment, and some believe that reliance on SOCs should be reduced. Broadening clear availability of deferred prosecutions to address co-occurring domestic violence and substance abuse, or domestic violence and mental health, might help to address this problem by providing a more regulated sentencing alternative.

Victim Safety

Sharing Treatment Information with Victims

The revised WACs include provisions requiring treatment programs to share information with victims in order to promote their safety. Pursuant to the revised WAC, 388-60A-0325(1), "[e]ach certified treatment program must adequately consider the safety of victims, current partners and children of the participants…" Steps that must be taken, as applicable, include:

(a) Notify the victim of each program participant before completing the assessment that the participant is being seen by the certified program for an assessment to determine:

[56] A good example of a highly regulated court-supervised use of SOCs exists as a tool in Seattle Municipal Court.

Key Differences Between System and Community-Based DV Advocates

While both system and community-based DV advocates are focused on victim safety, they differ as follows:

Confidentiality: Victims have privileged communications with community-based advocates under RCW 5.60.060(8), whereas communications with system-based advocates are not privileged.

Duration of Services: There is no limitation on duration of services for community-based advocacy, whereas services are limited to the length of the justice process for system advocacy.

Scope of Services: Community-based advocacy provides comprehensive victim-directed advocacy (e.g. crisis intervention, education, support groups) whereas system-based advocacy is specific to moving the victim through the system.

Services to Secondary Victims: Community-based advocates usually offer services to secondary victims, system-based advocates provide services specific to the direct victim.

(i) If domestic violence intervention treatment is appropriate for the participant, and if so, what level of treatment the participant will start in at the commencement of their program; and

(ii) If applicable, what other treatments will be required or recommended as part of the participant's treatment plan.

(b) Inform victims of specific outreach, advocacy, emergency and safety planning services offered by a domestic violence victim services program in their community; (A list of community-based Washington Domestic Violence Programs by county is provided in Appendix F)

(c) Notify the victim of each program participant within fourteen days of the participant being accepted or denied entrance to the program that the participant has enrolled in or has been rejected for treatment services;

(d) When the participant has been accepted into treatment, give victims a brief description of the domestic violence intervention treatment program including all of the following:

(i) The primary objective of the domestic violence intervention treatment program to help increase the safety of the victim and children as well as holding the participant accountable;

(ii) The core competencies and minimum completion criteria for the participant in treatment; and

(iii) The fact that the victim is not expected to do anything to help the participant complete any treatment program requirements;

(iv) The limitations of domestic violence intervention treatment; and

(v) The program's direct treatment staff's responsibility regarding mandated reporting and duty to warn.

Treatment programs have an obligation to document in writing their attempts to notify the victim.[57] While programs may meet the requirements of this section through an agreement or contract with a victim services program, it is the responsibility of the certified program to ensure and document that all requirements are met.

In addition to helping to better-promote victim safety, these victim notification requirements also ensure that treatment providers may gain access to additional information and insight that the victim could share that would be beneficial in treatment.

[57] WAC 388-60A-0325(4).

Work Group Recommendations re: Information, Therapeutic Courts, and Sentencing Alternatives

- To promote access to quality information to complete the assessment for DV treatment and monitor progress, this work group recommends the following approaches:
    - DV Courts should be organized as Therapeutic Courts.
    - As Therapeutic Courts, information related to domestic violence cases should be centralized in the courts, effectively creating an Information Repository. Access to information should be carefully balanced against protecting the privacy of victims and defendants.
    - Court structures should be selected to meet the needs of the local jurisdiction. By creating either:
        - A multi-disciplinary team (MDT) of professionals to meet regularly to discuss progress in treatment. This MDT model could be modified to meet the different staffing and resource considerations in different jurisdictions, or
        - Create or utilize an existing probation department, or
        - Create a regular review calendar for ongoing court monitoring to promote compliance with court-ordered treatment, when DV

treatment is ordered as a part of criminal or civil proceedings (family law, protection orders, dependencies[58]).

- We recommend implementing sentencing alternatives for DV crimes: For felonies, similar to the Drug Offender Sentencing Alternative (DOSA) and Special Sex Offender Sentencing Alternative (SSOSA) creating a "DVOSA," and for misdemeanors, clarify use of deferred prosecutions for cases with co-occurring substance abuse or mental health issues.
- Pursuant to protocol in the revised WAC 388-60A-0325, victims should be informed about assessments and level of perpetrator treatment, both to promote their safety and increased access to information that will support effective treatment.

Barriers to Accessibility of Domestic Violence Treatment

Reliable Funding

Domestic Violence Treatment is costly.[59] Moreover, the services provided by a state-certified domestic violence intervention program are typically not reimbursable by insurance. The cost of domestic violence treatment can be prohibitive, and often creates situations of noncompliance. It also leads to respondents seeking treatment from more affordable but less reputable providers. In the child welfare/dependency context, indigent parents are sometimes required to pay for some or all of their domestic

[58] Dependencies in our state are generally treated separately with their own "Dependency Court" routine.
[59] See e.g., Rain & Sanders, "It's Just a Misdemeanor A Look at Washington's Broken Probation Model" (NW Lawyer, Nov 2016) which lists the average one-year domestic violence treatment program at $1,400. An informal survey of treatment programs around Washington found the fee for an assessment to range from $100-$250 and that weekly groups typically cost between $30-45 per session.

violence treatment contrary to RCW 13.34.025. This unauthorized cost shifting, in the dependency realm, often creates delays in cases and in permanency for children.

In order to conduct a thorough intake, it is necessary to gather a substantial amount of information, and in many cases, the fee charged does not cover the amount of time spent by a program to gather, understand, and document the information. When programs are expected to charge a lower fee for an assessment they are faced with the decision to either: 1) cut corners on their assessment process, which can lead to missing important information relevant to victim safety, or 2) lose money in this process of providing a free service to the client and the court. This is not a sustainable model. Moreover, these pressures create a disincentive for maintaining ethical practice and may tend to push ethical treatment providers out of the system.

Additionally, many components to ethical and responsible domestic violence intervention are non-billable (e.g. victim contact, collateral contact with other providers and probation, writing monthly progress reports, etc.) Many of these essential components are part of the minimum standards for domestic violence intervention programs, and a program must do these things or risk jeopardizing state certification.

Ultimately, a reliable funding scheme for all court-ordered domestic violence treatment contemplates alternative methods to reduce or defer the cost of treatment. These methods might include: alternative financing methods of treatment cost; requiring insurance companies to cover DV treatment; and government subsidy of the cost of treatment.

Recognizing that mandating insurance coverage[60] for domestic violence treatment will be a longer-term process, the Work Group discussed other innovative approaches being taken throughout the state that might be adopted in the interim to reduce or remove cost as a barrier to effective treatment:

Sliding-scale approach: Treatment programs could adopt a sliding fee scale based on participants' ability to pay. For example, in the City of Seattle's DVIP pilot (see Appendix E), there is a $25 per week minimum for the program. The shortfall to the two treatment providers involved in the pilot is city-subsidized. In the past, treatment providers report that they have also subsidized fee shortfalls in their sliding scale programs by private grants.[61] This approach is not likely sustainable for most treatment providers without government or private subsidy; however, more data is needed to support what monetary contributions would look like. Grant-funded programs piloted as best practices (such as the City of Seattle's DVIP pilot) could provide some future guidance.

Government Subsidy/Guarantee: Municipalities, where possible, could advance the majority of the treatment cost to the individual in exchange for a payment plan secured (in the event of nonpayment) by a note or judgment. Additionally, the Work Group recommends that the Legislature explore the cost savings involved in requiring treatment versus the cost of incarceration. In the area of substance abuse treatment,

[60] However, the proponents of this idea see a clear analogy to the revolution in required DUI treatment and the coverage of substance abuse treatment by insurance.
[61] In King County, *United Way of King County* had a grant program that ended in 2017.

researchers have reported that treatment is less expensive than incarceration.[62] If the analogy can be made to DV treatment, then it would be efficient to explore re-allocation of a portion of the funds earmarked for incarceration to subsidize treatment. Such subsidies would seek to take advantage of the potential savings of treatment over incarceration.[63]

DV Moral Reconation Therapy (DV-MRT): This is a cognitive behavioral approach to treatment that seeks to decrease recidivism by increasing moral reasoning.[64] Delivery of this treatment approach is via group and individual counseling. In addition to a few domestic violence treatment programs, several probation departments around the state of Washington[65] have adopted this treatment approach. These courts have done so because traditional domestic violence treatment programs are not affordable or available for defendants in those jurisdictions, and the court can provide the program at a reduced rate.[66] In conjunction with the revisions to

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[62] *See e.g.* McVay, Schiraldi, and Ziedenberg, "Justice Policy Institute Report: Treatment or Incarceration? National and State Findings on the Efficacy and Cost Savings of Drug Treatment Versus Imprisonment," (January 2004).

[63] Appropriate treatment for an offender has long been reported to be cost effective. In California in 2003, the average cost of one year of substance abuse treatment of about $4,500 was far less than the $27,000 per inmate cost per year. See *Treatment or Incarceration? National and State Findings on the Efficacy and Cost Savings of Drug Treatment Versus Imprisonment*, Justice Policy Institute (January 2004). Since at least the early 2000's Washington State Institute for Public Policy (WSIPP) has also reported the cost effectiveness of treatment as opposed to incarceration, as well as reducing recidivism: *The Comparative Costs and Benefits of Programs to Reduce Crime* (May 2001); *Washington State's Drug Courts for Adult Defendants: Outcome Evaluation and Cost-Benefit Analysis* (March 2003); *What Works and What Does Not? Benefit-Cost Findings from WSIPP* (February 2015).

[64] Please see https://www.ccimrt.com/mrt_programs/domestic-violence/

[65] Cheney Municipal Court, Edmonds Municipal Court, Everett Municipal Court, Snohomish County District Court, Bellevue Probation, SeaTac Municipal Court, Tukwila Municipal Court, Walla Walla District Court

[66] The cost to the courts to train personal to deliver DV-MRT ranges between $600-$2,600 per person. In Tukwila Municipal Court, for example, the cost to the defendant is $100 for the 6-month program, which covers the cost of materials.

the WACs governing DV perpetrator treatment, probation departments that have been utilizing the DV-MRT approach are in the process of negotiating WAC compliance certification with DSHS.

Another example is King County's Promoting Peace and Recovery program. This program is funded by King County, free to offenders, operational, and a next step development to DV-MRT for cases of co-occurring domestic violence and substance abuse. The program operates in a day reporting environment following clinical assessment, and uses risk, need, responsivity tools. The program is being evaluated by King County Behavioral Health and the Ballmer Foundation, and began with a limited randomized control trial.

Despite DV-MRT's basis in cognitive behavioral therapy, at least one group member is strongly opposed to DV-MRT programs because DV-MRT's "workbook" approach undermines and/or is inferior to programs which utilize group therapy. However, our proposed Integrated System Response allows us to embrace the entire gamut of views because research will apply to all equally, and programs will be required to meet the test of efficacy, which will then no longer be simply a matter of opinion.

The Urban/Rural Problem

Closely related to the issue of cost is the lack of sufficient DV service providers in the state of Washington. There are currently (as of May 2, 2018) 85 certified DV service providers in the State of Washington. King County and Pierce County have the most

providers with 18 and 15, respectively. The following counties have no certified DV service providers: Adams, Asotin, Columbia, Douglas, Garfield, Jefferson, Kittitas, Klickitat, Lincoln, Okanogan, Pacific, Pend Oreille, San Juan, Stevens, Walla Walla, and Whitman. While the revised WAC 388-60A-0345 does include attendance of group via videoconference as an alternative delivery method for treatment, this is not an option for all service providers.

Language

Language barriers are being addressed differently throughout the State of Washington. There are some programs that require clients to pay for an interpreter, while other programs share the cost of an interpreter with their clients. These arrangements are worked out on a case-by-case basis; therefore, there is no program data available.

Cultural Competency, Equity and Social Justice

Offenders in domestic violence treatment vary widely in demographics, legal history, and from civil to criminal cases. Offenders are diverse in race, ethnicity, immigration status, acculturation and other factors that often influence attitudes toward the legal system, domestic violence, treatment or therapy. The lack of cultural responsiveness in DV treatment has been identified as an issue by many sources, including the Center for Latino Health, University of Washington. An excerpt from a

research proposal from the Center for Latino Health and the King County Prosecuting Attorney states:

> *The literature identifies the model's (Duluth) lack of attention to contextual and cultural factors that influence the lives of diverse ethnic minority populations as a serious limitation and contributes to higher dropout rates and poorer treatment outcomes among Latino and African American men than White men (Parra-Cardona et al., 2013).*

Cultural responsivity is essential to ensuring equity and social justice for all offenders. The Work Group is unable to address this adequately because of time and composition; however, we recommend that in any further implementation of the process that the responsible individuals pursue a rigorous outreach to diverse communities to inquire what they feel is needed to ensure equity in the DV treatment system. This outreach should be guided by existing research in the area of implicit bias (in systemic process and participants), particularly with regard to risk assessment instruments.[67] Incentives should be built into the process to encourage culturally sensitive program development, hiring and training. Individuals from diverse groups and organizations such as: Tribal State Court Consortium, the National Association for the Advancement of Colored People (NAACP), Familias Unidas, Center for Latino Health, Minority Bar Associations, and others, should be permanent members of any "standing body" appointed by the governor to implement this process.

[67] See Washington State Supreme Court Minority and Justice Commission work on this issue, available at http://www.courts.wa.gov/?fa=home.sub&org=mjc&page=publications&layout=2&showPubTab&tab=pubRes

Work Group Recommendations re: Treatment Accessibility

- The Section 7 work group suggests the following to create a reliable funding scheme for all court-ordered DV treatment:
    - Legislation requiring insurance companies to pay for a portion of the cost of domestic violence perpetrator treatment.
    - In the interim,
        - Municipalities could accept secured payment plans[68] from defendants.
        - Domestic Violence treatment programs or Domestic Violence Courts could adopt sliding scale fee programs, with government or private subsidies for some portion of the treatment costs. Data should be collected to determine the requisite funding to make programs sustainable.
        - The Legislature could develop a plan of subsidies based on the potential savings of treatment versus incarceration.
        - Courts could provide alternative treatment options such as DV-MRT, which can be offered at a lower cost to defendants. More data is needed to analyze the effectiveness of such programs.

[68] This is a payment plan secured by a note or judgment in the event of nonpayment.

- Reliable funding for court-ordered DV programs may incentivize maintenance of existing DV treatment programs and the creation of new ones to make DV perpetrator treatment more widely available in Washington.
- This work group encourages the collection and reporting of data from treatment providers related to the number of clients requiring the services of an interpreter, as well as the languages needed. Additionally, treatment providers should report how they handle the cost of interpreters. Once collected, this information could be used to determine how to remove or diminish access issues due to language.
- The work group encourages further work to promote cultural competency, equity, and social justice within domestic violence treatment programs.

ISR Process Implementation: Ongoing Direction: New Entity

We realize that the "process" described that represents many of the recommendations contained in this report may need ongoing supervision. Implementing improvements to DV treatment response, which have been ignored for so long, necessitates a standing body appointed by the governor for oversight.[69] We recommend this type of active, ongoing oversight, via a governor appointed standing body, be created (E.g., a "Domestic Violence Policy Review Board").

[69] A similar oversight, the Sex Offender Policy Review Board, was established for sex offense cases pursuant to RCW 9.94A.8673.

Training DV Professionals

Training

An understanding of domestic violence is critical for all professionals who work on or come into contact with these cases. There are several trainings held in the state of Washington each year on the topic of domestic violence.[70] Resources are also available for professionals working in the field (law enforcement, attorneys, social workers, judicial officers). [71] However, the training requirements are perceived as unstructured and sporadic. Unfortunately, training for mental health and substance abuse professionals regarding domestic violence is also limited.

[70] The Children's Justice Conference is an annual statewide multidisciplinary training held in the spring that often features trainings on domestic violence in the child welfare context. http://dshscjc.com/. There is a Domestic Violence Symposium held in Seattle each fall. https://www.regonline.com/builder/site/Default.aspx?EventID=1997182. The Washington State Coalition Against Domestic Violence (WSCADV) hosts an annual conference. https://wscadv.org/projects/annual-conference/. All new judicial officers are required to attend an in-person course on the topic of Domestic Violence, developed and sponsored by the Washington State Supreme Court Gender and Justice Commission. The course is offered annually. Additionally, there are judicial conferences in Washington State each year in the spring and the fall, at which the Gender and Justice Commission sponsors workshops, which often focus on current and emerging gender-based violence issues. When resources allow, the Gender and Justice Commission also sponsors training on domestic violence for court administrators and staff. Pursuant to RCW 10.99.030, Washington's Criminal Justice Training Commission shall include at least 20 hours of basic training on the law enforcement response to domestic violence, as well as developing and updating an annual in-service training.

[71] Domestic Violence Bench Guide for Judicial Officers (Rev. 2015) http://www.courts.wa.gov/index.cfm?fa=home.contentDisplay&location=manuals/domViol/index, Social Workers Practice Guide to Domestic Violence (2010) https://wscadv.org/wp-content/uploads/2015/05/social_workers_practice_guide_to_dv_feb_2010.pdf, Prosecutors' Domestic Violence Handbook (2012) http://www.waprosecutors.org/MANUALS/DV/WAPA%20KCPAODV%20Manual%2012.11.14.pdf,

Often, professionals from other disciplines misapply well-intended concepts such as family systems theory[72] or co-dependency[73] to the issue of domestic violence. These concepts can undermine a domestic violence perpetrator's personal accountability for their abusive behavior.

Work Group Recommendations re: Training

- All professionals working on Domestic Violence cases should be required to receive regular and ongoing training in the area of Domestic Violence. All training must be culturally sensitive.
- Require all DSHS social workers to be trained in and follow the *Social Workers Practice Guide to Domestic Violence (2010).*
- It is further recommended that increased funding be made available for programs and state agencies to send staff to such trainings.
- Finally, make funding for Domestic Violence available to create or update existing educational resources for all professionals working on these cases.

[72] Family systems therapy is a form of psychotherapy where families work together better understand their group dynamic and how their individual actions affect each other and the family unit as a whole.
[73] Co-dependency theory refers to one's dependence on the needs of, or control of, another.

SUMMARY OF SECTION 7 WORK GROUP RECOMMENDATIONS

Existing Laws and Regulations

- Embrace the adoption of the revised Chapter 388-60A WAC. The revisions support the Integrated System Response (ISR) principles and methodology the group concluded was needed.
- Pass legislation to bifurcate the definition of Domestic Violence in RCW 26.50.010 into cases involving intimate partner violence and those involving the broader relational definition. This would not substantively change the definition of Domestic Violence; it would be a technical change to refine the statute to promote the better collection of data for analysis and quality improvement, as well as supporting appropriate referral into treatment.
- Designate DV Courts as Therapeutic Courts. Information related to domestic violence cases should be centralized in the courts, effectively creating an Information Repository. Access to information should be carefully balanced against protecting the privacy of victims and defendants. Court structures should be selected to meet the needs of the local jurisdiction. By creating either:
    - A multi-disciplinary team (MDT) of professionals to meet regularly to discuss progress in treatment. This MDT model could be modified to meet the different staffing and resource considerations in different jurisdictions, or

- Create or utilize an existing probation department, or
- Create a regular review calendar for ongoing court monitoring to promote compliance with court-ordered treatment, when DV treatment is ordered as a part of criminal or civil proceedings (family law, protection orders, dependencies).

- Mandate five years' probation for all intimate partner DV sentences. This in order to ensure the completion of treatment, monitoring of compliance with the conditions of sentences and the collection of needed information to ensure effectiveness. Active probation should be required until domestic violence treatment is completed, after which inactive probation could be imposed for the remainder of the five-year period.

Court and Agency Practices

- Allocate sufficient funds to enable DSHS to regulate domestic violence treatment agencies and enforce compliance with the revised Chapter 388-60A WAC.
- Collect data for further evaluation of the efficacy of DV treatment, including whether treatment was ordered, and whether treatment was completed.
- Require law enforcement, lawyers, judges, and other professionals working on domestic violence cases undergo regular domestic violence-related training. How that training is implemented should be left to the discretion of the various entities.

Victim Safety

- Adhere to the new victim notification requirements in WAC 388-60A-0325. This supports victim safety by requiring that victims be informed of assessments and level of perpetrator treatment. Moreover, where determinations of lethality are concerned, the best source of information is the victim.

Decrease Recidivism

- Comply with the revised Chapter 388-60A WAC. It implements a system of compliance with **core competencies in treatment**[74] that are state of the art and a

[74] **388-60A-0430 Completion criteria and core competencies – What is required for a participant to complete treatment?**
(1) The program must ensure:
(a) The participant has met the program's written criteria for satisfactory completion of treatment including:
(i) Cooperation with all program rules and requirements;
(ii) The goals or objectives of the participant's treatment plan; and
(iii)The minimum treatment period and requirements.
(b) The participant has attended and complied with all other treatment sessions required by the program, which may include ancillary treatment such as mental health, substance use or parenting treatment;
(c) The participant is in compliance with all court orders;
(i) If the participant is court ordered to pay spousal or child support and is behind on payments, the participant may show a payment plan agreement and documentation that they have been in compliance with the plan for a minimum of six months in order to be in compliance with this requirement.
(d) Coverage of all treatment topics, the completion of all assignments, and the requirements as outlined in the level of treatment in which they participated.
(2) In order to complete levels one, two or three treatment the program must also document the following in the participant's file:
(a) The participant has successfully demonstrated core competencies:
(i) Accountability and adherence to the participant's accountability plan;
(ii) Increased victim safety as evidenced by written documentation of the participant's demonstration of a change in their beliefs which have resulted in the participant's cessation of all violent acts or threats of violence for a minimum of the last six months;
(iii) Knowledge of their personal primary motivations for abusive or controlling behaviors and alternative ways to meet their needs in a non-abusive manner.
(3) In order to complete level four treatment, the program must document the following in the participant's file:
(a) The participant's plan for how they will meet their needs in non-abusive, legal and healthy ways;
(b) The problem solving and self-control skills the participant has learned and demonstrated in treatment to deal with unpleasant feelings; and

direct implementation of evidence-based practices. Core competencies are the elements of what a perpetrator must meet in order to be considered as having completed treatment. Evidence-based treatment has been shown to reduce recidivism. The core competencies are rooted in cognitive behavioral therapy approaches[75] and would effectively expand compliance with cognitive behavioral therapy (CBT) throughout our state. We see this as a major advance and we see it as implementation of the recommendations made in the 2013 WSIPP reports and those subsequent.

- Authorize adequate, ongoing, and multi-year funding for statewide monitoring, research and evaluation to assess the efficacy of domestic violence perpetrator treatment following implementation of the revised Chapter 388-60A WAC.

Advance Treatment Outcomes

- Promote access to quality information to complete the assessment for DV treatment and monitor progress, by centralizing information in a "data repository" in the courts or by adopting a Therapeutic Courts approach.
- It is further recommended that increased funding be made available for programs and state agencies to be able to send staff to such trainings, and to make resources on Domestic Violence available to, or to update existing resources for, all

(c) The program's assessment of satisfactory changes to the participant's environmental factors such as peer groups, employment or substance use.

[75] Refer to Appendix G

professionals working on these cases. Require all DSHS social workers to be trained in and follow the *Social Workers Practice Guide to Domestic Violence (2010).*

- Create a reliable funding scheme for all court-ordered domestic violence treatment by requiring insurance companies to cover a portion of the cost of treatment. Stop gap measures in the interim include courts accepting secured payment plans, providing government subsidies to sustain programs operating on a sliding scale fee basis, or by providing additional funding to the courts to provide alternative programs such as DV Moral Reconation Therapy (MRT). The Legislature should explore the cost savings of DV treatment in order to re-allocate funds from incarceration to treatment based on the savings involved.
- Require domestic violence treatment providers to collect and report on data related to cultural and linguistic competency. This information collected could be used to inform how to remove treatment barriers.

Increase the Courts' Confidence in DV Treatment

- Authorize adequate, ongoing, and multi-year funding for statewide monitoring, research and evaluation to assess the efficacy of domestic violence perpetrator treatment following implementation of the revised Chapter 388-60A WAC.
- Create a state level "standing body" appointed by the governor to provide guidance for implementing and oversight of this process.
- Ensure equity and social justice for all system participants by promoting cultural responsiveness in DV treatment via community outreach; active utilization and

guidance by research on implicit bias; use of unbiased risk assessment instruments; incentives to encourage culturally sensitive program development, hiring and training; and appointment representation in any standing body of diverse groups.

CONCLUSION

The Work Group understands that restoring confidence in the value of treating domestic violence offenders will not happen overnight. But it can happen. The Work Group believes that success will come by the implementation of innovative methods and instituting "rigorous" research and evaluation to ensure the efficacy of that innovative methodology. The efforts of the Section 7 Work Group have been focused on addressing these issues, and we believe that our recommendations, if followed, will put a productive process in place. We believe this process will promote evidence-based treatment, the involvement and protection of victims, and will efficiently verify and improve the system via monitoring and ongoing research. We believe that an Integrated System Response (ISR) will be effective in expanding and improving DV treatment in Washington State in order to reduce recidivism.

Appendices

Appendix A: Table of Contents: Domestic Violence Manual for Judges (2016)[76]

[76] Full document available at http://www.courts.wa.gov/index.cfm?fa=home.contentDisplay&location=manuals/domViol/index

Appendix B: Table of Contents: Social Workers Practice Guide to Domestic Violence (2010)[74]

Table of Contents

[74] Full document available at https://wscadv.org/wp-content/uploads/2015/05/social_workers_practice_guide_to_dv_feb_2010.pdf

Appendix C: DV Treatment Documentation of Cognitive and Behavioral Change

Describe the connection between thoughts, feelings and behaviors using a CBT-based model (e.g., Cognitive Triangle; Antecedents, Behaviors, Consequences; Chain Analysis) as applied to at least two episodes where you engaged in intimate partner violence.
Answers:
List at least 3-5 beliefs, attitudes, cognitions, or attributions that facilitated your intimate partner violence. Describe your current beliefs that inhibit and/or do not support or facilitate intimate partner violence. Describe specifically.
Answers:
Describe the emotional regulation or coping skills you have learned to manage intense distressing emotions that are frequently connected to intimate partner violence (e.g., anger, frustration, jealousy, resentment, insecurity). Describe at least 3 recent incidents where you experienced the emotions and successfully used a coping skill to lower the intensity of your emotional reactions so you could respond effectively. Describe in detail.
Answers:
List the skills you have learned and use to achieve your goals in ways that do not involve intimate partner violence, threats, coercion, violence toward others, anti-social behavior. Give at least 3 examples of recent situations where you effectively used one or more of these skills. Describe in detail.
Answers:

Appendix D: Proposal to Amend GR 22 to Include Therapeutic Courts

Therapeutic courts are defined under RCW 2.30.010. This amendment would further the goal of therapeutic courts to provide individualized treatment intervention. Limited public access to assessments and treatment reports would help encourage defendants to cooperate more honestly with risk/needs assessments, mental health and chemical dependency evaluations, and treatment.

GR 22

ACCESS TO FAMILY LAW ~~AND,~~ GUARDIANSHIP AND THERAPEUTIC COURT RECORDS

(Comments not included)

(a) Purpose and Scope of this Rule. This rule governs access to family law, ~~and~~ guardianship and therapeutic court records, whether the records are maintained in paper or electronic form. The policy of the courts is to facilitate public access to court records, provided that such access will not present an unreasonable invasion of personal privacy, will not permit access to records or information defined by law or court rule as confidential, sealed, exempted from disclosure, or otherwise restricted from public access, and will not be unduly burdensome to the ongoing business of the courts.

(b) Definition and Construction of Terms.

(1) "Court record" is defined in GR 31 (c)(4).

(2) "Family law case or guardianship case" means any case filed under Chapters 11.88, 11.92, 26.09, 26.10, 26.12, 26.18, 26.21, 26.23, 26.26, 26.27, 26.50, 26.52, 73.36 and 74.34 RCW.

(3) "Personal Health Care Record" means any record or correspondence that contains health information that: (1) relates to the past, present, or future physical or mental health condition of an individual including past, present, or future payments for health care; or (2) involves genetic parentage testing.

(4) "Personal Privacy" is unreasonably invaded only if disclosure of information about the person or the family (a) would be highly offensive to a reasonable person and (b) is not of legitimate concern to the public.

(5) "Public access" means unrestricted access to view or copy a requested court record.

(6) "Restricted personal identifiers" means a party's social security number, a party's driver's license number, a party's telephone number, financial account numbers, social security number of a minor child and date of birth of a minor child.

(7) "Retirement plan order" means a supplemental order entered for the sole purpose of implementing a property division that is already set forth in a separate order or decree in a family law case. A retirement plan order may not grant substantive relief other that what is set forth in a separate order. Examples of retirement plan orders are orders that implement a division of retirement, pension, insurance, military, or similar benefits as already defined in a decree of dissolution of marriage.

(8) "Sealed financial source documents" means income tax returns, W-2s and schedules, wage stubs, credit card statements, financial institution statements, checks or the equivalent, check registers, loan application documents, and retirement plan orders, as well as other financial information sealed by court order.

(9) "Therapeutic court cases" means any case in which a party is receiving treatment pursuant to a therapeutic court program under Chapter 2.30.

(c) Access to Family Law, ~~or~~ Guardianship and Therapeutic Court Records.

(1) General Policy. Except as provided in RCW 26.26.610(2) and subsections (c)(2) and (c)(3) below, all court records shall be open to the public for inspection and copying upon request. The Clerk of the court may assess fees, as may be authorized by law, for the production of such records.

(2) Restricted Access. The Confidential Information Form, Sealed Financial Source Documents, Domestic Violence Information Form Notice of Intent to Relocate required by RCW 26.09.440, Sealed Personal Health Care Record, Retirement Plan Order, Confidential Reports as defined in (e)(2)(B), copies of any unredacted Judicial Information System (JIS) database information considered by the court for parenting plan approval as set forth in
(f) of this rule, ~~and~~ any Personal Information Sheet necessary for JIS purposes shall only be accessible as provided in sections (h) and (i) herein, Therapeutic Court risk/needs assessments, and treatment evaluation and treatment compliance forms used in Therapeutic Courts

(3) Excluded Records. This section (c) does not apply to court records that are sealed as provided in GR 15, or to which access is otherwise restricted by law.

(d) Restricted Personal Identifiers Not Required - Except. Parties to a family law case or the protected person in a guardianship case shall not be required to provide restricted personal identifiers in any document filed with the court or required to be provided upon filing a family law or guardianship case, except:

(1) "Sealed financial source documents" filed in accordance with (g)(1).

(2) The following forms: Confidential Information Form, Domestic Violence Information Form, Notice of Intent to Relocate required by RCW 26.09.440, Vital Statistics Form, Law Enforcement Information Form, Foreign Protection Order Information Form, ~~and~~ any Personal Information Sheet necessary for JIS purposes, Therapeutic Court risk/needs assessments, and treatment evaluation and compliance forms used in Therapeutic Courts

(3) Court requested documents that contain restricted personal identifiers, which may be submitted by a party as financial source documents under the provisions of section (g) of this rule.

(e) Filing of Reports in Family Law, ~~and~~ Guardianship and Therapeutic Court cases--Cover Sheet.

(1) This section applies to documents that are intended as reports to the court in Family law, and Guardianship and Therapeutic Court cases including, but not limited to, the following:

(A) Parenting evaluations;

(B) Domestic Violence Assessment Reports created by Family Court Services or a qualified expert appointed by the court, or created for Therapeutic Court purposes;

(C) Risk Assessment Reports created by Family Court Services or a qualified expert, or risk/needs assessments created for use in a Therapeutic Court;

(D) Treatment evaluation and compliance reports required by a Therapeutic Court;

~~(D)~~ (E) CPS Summary Reports created by Family Court Services or supplied directly by Children's Protective Services;

~~(E)~~ (F) Sexual abuse evaluations; and

~~(F)~~ (G) Reports of a guardian ad litem or Court Appointed Special Advocate.

(2) Reports shall be filed as two separate documents, one public and one sealed.

(A) Public Document. The public portion of any report shall include a simple listing of:

(i) Materials or information reviewed;

(ii) Individuals contacted;

(iii) Tests conducted or reviewed; and

(iv) Conclusions and recommendations.

(B) Sealed Document. The sealed portion of the report shall be filed with a coversheet designated: "Sealed Confidential Report." The material filed with this coversheet shall include:

(i) Detailed descriptions of material or information gathered or reviewed;

(ii) Detailed descriptions of all statements reviewed or taken;

(iii) Detailed descriptions of tests conducted or reviewed; and

(iv) Any analysis to support the conclusions and recommendations.

(3) The sealed portion may not be placed in the court file or used as an attachment or exhibit to any other document except under seal.

(f) Information Obtained from JIS Databases with Regard to Approval of a Parenting Plan.

When a judicial officer proposes to consider information from a JIS database relevant to the placement of a child in a parenting plan, the judicial officer shall either orally disclose on the record or disclose the relevant information in written form to each party present at the hearing, and, on timely request, provide any party an opportunity to be heard regarding that information. The judicial officer has discretion not to disclose information that he or she does not propose to consider. The judicial officer may restrict secondary dissemination of written unredacted JIS database information not available to the public.

(g) Sealing Financial Source Documents, Personal Health Care Records, and Sealed Confidential Reports in Family Law and Guardianship cases--Cover Sheet.

(1) Financial source documents, personal health care records, confidential reports as defined in (e)(2)(B) of this rule, and copies of unredacted JIS database records considered by the court for parenting plan approval as set forth in (f) of this rule, shall be submitted to the clerk under a cover sheet designated "SEALED FINANCIAL SOURCE DOCUMENTS," "SEALED PERSONAL HEALTH CARE RECORDS," "SEALED CONFIDENTIAL REPORT" or "JUDICIAL INFORMATION SYSTEM DATABASE RECORDS" for filing in the court record of family law or guardianship cases.

(2) All financial source documents, personal health care records, confidential reports, or JIS database records so submitted shall be automatically sealed by the clerk. The cover sheet or a copy thereof shall remain part of the public court file.

(3) The court may order that any financial source documents containing restricted personal identifiers, personal health care records, any report containing information described in (e)(2)(B), or copies of unredacted JIS database records considered by the court for parenting plan approval as described in (f) be sealed, if they have not previously automatically been sealed pursuant to this rule.

(4) These cover sheets may not be used for any documents except as provided in this rule. Sanctions may be imposed upon any party or attorney who violates this rule.

(h) Access by Courts, Agencies, and Parties to Restricted Documents.

(1) Unless otherwise provided by statute or court order, the following persons shall have access to all records in family law or guardianship cases:

(A) Judges, commissioners, other court personnel, the Commission on Judicial Conduct, and the Certified Professional Guardian Board may access and use restricted court records only for the purpose of conducting official business of the court, Commission, or Board.

(B) Any state administrative agency of any state that administers programs under Title IV-A, IV-D, IV-E, or XIX
of the federal Social Security Act.

(2) Except as otherwise provided by statute or court order, the following persons shall have access to all documents filed in a family law or guardianship case, except the Personal Information Sheet, Vital Statistics Form, Confidential Information Form, Domestic Violence Information Form, Law Enforcement Information Form, and Foreign Protection Order Form.

(A) Parties of record as to their case.

(B) Attorneys as to cases where they are attorneys of record.

(C) Court appointed Title 11 guardians ad litem as to cases where they are actively involved.

(i) Access to Court Records Restricted Under This Rule.

(1) The parties may stipulate in writing to allow public access to any court records otherwise restricted under section (c)(2) above.

(2) Any person may file a motion, supported by an affidavit showing good cause, for access to any court record otherwise restricted under section (c)(2) above, or to be granted access to such court records with specified information deleted. Written notice of the motion shall be provided to all parties in the manner required by the Superior Court or Courts of Limited Jurisdiction Civil Rules. If the person seeking access cannot locate a party to provide the notice required by this rule, after making a good faith reasonable effort to provide such notice as required by the Superior Court or the Courts of Limited Jurisdiction Rules, an affidavit may be filed with the court setting forth the efforts to locate the party and requesting waiver of the notice provision of this rule. The court may waive the notice requirement of this rule if the court finds that further good faith efforts to locate the party are not likely to be successful, or if the motion requests access to redacted JIS database records.

(A) The court shall allow access to court records restricted under this rule, or relevant portions of court records restricted under this rule, if the court finds that the public interests in granting access or the personal interest of the person seeking access outweigh the privacy and safety interests of the parties or dependent children.

(B) Upon receipt of a motion requesting access, the court may provide access to JIS database records described in (f) after the court has reviewed the JIS database records and redacted pursuant to GR 15(c), any data which is confidential or restricted by statute or court rule.

(C) If the court grants access to restricted court records, the court may enter such orders necessary to balance the personal privacy and safety interests of the parties or dependent children with the public interest or the personal interest of the party seeking access, consistent with this rule.

Appendix E: City of Seattle's DVIP Pilot

DVIP Pilot Program and Talking Points

History of DVBT/BIP

- Based on the feminist model of male entitlement with a focus on accountability (this was to counter the prevailing belief that women were responsible for the abuse)
- Over time and with the criminalization of DV, programs relied on court ordered clients as a revenue stream and DVBT became a "one size fits all" solution to DV (family law, misdemeanor and felony).
- Utilized the "Duluth Model," which emphasized a community coordinated response. However, many communities lacked that coordination.
- In the 2000s, many of the good programs started to incorporate trauma-informed care and motivational interviewing, recognizing that many batterers were victims as a child. They were also realizing that focusing purely on accountability without looking at the underlying reasons for the behavior was not effective.

WSIPP Study

- In 2013, the Washington State Institute for Public Policy published a study that showed "no effect on DV recidivism with the Duluth model." The study was a meta-analysis (review of other studies) of quantitative research only, none of which were in Washington State.
- The court stopped ordering DV treatment as a routine matter.

Changes to WAC 388-60-0015

- In response to the WSIPP study and the recognition that a lack of oversite could contribute to a lack of effectiveness for programs, the state convened a work group to revise the WACs. SMC Probation was included in that work group, as was Wellspring Family Services.
- Major changes to the WAC include:
    - Requirement of a more intense risk and needs assessment prior to entering a program
    - Mandates on-going risk assessment, as risk factors (such as employment) can change
    - Assessment determines which level of treatment 1-4, which differ in length
    - Program is individualized according to the risk/needs assessment
    - Progress in the program is determined by specific behavior and belief changes
    - Greater program accountability; must report status and data to the state quarterly
    - Focus of the program continues to be victim safety, and program must notify victims when perpetrator enrolls and leaves treatment
- These changes will affect ALL DV treatment programs starting in June.

Seattle's DV Intervention Program Pilot: DVIP

- Based on the Colorado model which has shown to be a promising practice: https://www.colorado.gov/pacific/dcj/domestic-violence-offender-management
- Includes extensive risk/needs assessment to determine level of treatment needed and whether any adjunct treatment is needed (individual DV treatment, MH or CD treatment)

- Incorporating mental health and chemical dependency treatment into DV programs has shown to have significant impact on recidivism— 33% reduction in reviewed programs. (WSIPP)
- Multi-disciplinary team will include advocates, probation, treatment providers (providing the community coordinated response that the Duluth model envisioned)
- Treatment provided by 2 well regarded organizations: Wellspring Family Services and Asian Counseling and Referral Service
- Community supervision of domestic abusers after a comprehensive risk needs assessment has shown a 16% reduction in recidivism. (WSIPP)
- All facets of the program are evidence-based.

Appendix F: Washington Domestic Violence Advocacy Programs – By County[78]

Adams County

- New Hope DV/SA Services, Moses Lake, WA. Office: (509) 764-8402, Crisis Line: (888) 560-6027

Asotin County

- YWCA of Lewiston/Clarkston, Lewiston, ID. Office: (208) 743-1535, Crisis Line: (800) 669-3176

Benton County

- DV Services of Benton & Franklin Counties, Kennewick, WA. Office: (509) 735-1295, Crisis Line: (509) 582-9841

Chelan County

- NW Immigrant Rights Project, Wenatchee, WA. Office: 509.570.0054, Crisis Line: 866.271.2084
- Sage, Wenatchee, WA. Office: (509) 663-7446, Crisis Line: (509) 663-7446

Clallam County

- Forks Abuse Program, Forks, WA. Office: (360) 374-6411, Crisis Line: (360) 374-2273
- Healthy Families of Clallam County, Port Angeles, WA. Office: (360) 452-3811, Crisis Line: (360) 452-4357
- Lower Elwha Klallam Tribe – Family Advocacy Program, Port Angeles, WA. Office: (360) 565-7257

Clark County

- Cowlitz Indian Tribe – Pathways to Healing, Vancouver, WA. Office: (360) 397-8228
- YWCA Clark County/Safe Choice, Vancouver, WA. Office: (360) 696-0167, Crisis Line: (800) 695-0501

[78] https://wscadv.org/washington-domestic-violence-programs/ (last viewed 5/18/18)

Columbia County

- YWCA – Walla Walla, Dayton, WA. Office: (509) 382-9922, Crisis Line: (509) 382-9922

Cowlitz County

- Emergency Support Shelter, Kelso, WA. Office: (360) 425-1176, Crisis Line: (360) 636-8471

Douglas County

- Sage, Wenatchee, WA. Office: (509) 663-7446, Crisis Line: (509) 663-7446

Ferry County

- Rural Resources Victim Services, Coleville, WA. Office: (509) 684-3796, Crisis Line: (509) 684-6139 or 844-509-SAFE (7233)

Franklin County

- DV Services of Benton & Franklin Counties, Kennewick, WA. Office: (509) 735-1295, Crisis Line: (509) 582-9841

Garfield County

- YWCA of Lewiston/Clarkston, Lewiston, ID. Office: (208) 743-1535, Crisis Line: (800) 669-3176

Grant County

- New Hope DV/SA Services, Moses Lake, WA. Office: (509) 764-8402, Crisis Line: (888) 560-6027

Grays Harbor County

- Chehalis Confederated Tribe – Domestic Violence Program, Oakville, WA. Office: (360) 273-5911, Crisis Line: (360) 709-1874
- Domestic Violence Center of Grays Harbor, Hoquiam, WA. Office: (360) 538-0733, Crisis Line: (800) 818-2194

Island County

- Citizens Against Domestic & Sexual Abuse (CADA), Oak Harbor, WA. Office: (360) 675-7057, Crisis Line: (800) 215-5669

Jefferson County

- DOVE House Advocacy Services, Port Townsend, WA. Office: (360) 385-5292, Crisis Line: (360) 385-5291

King County- Seattle Area

- Abused Deaf Women's Advocacy Services (ADWAS), Seattle, WA. Office: (206) 922-7088 TTY, Crisis Line: (206) 812-1001
- API Chaya, Seattle, WA. Office: (206) 568-7576
- Consejo Counseling & Referral Services, Seattle, WA. Office: (206) 467-9976
- The DoVE Project, Vashon, WA. Office: (206) 715-0258, Crisis Line: (206) 462-0911
- Jewish Family Services – Project DVORA, Seattle, WA. Office: (206) 461-3240, Crisis Line: (206) 461-3222
- New Beginnings, Seattle, WA. Office: (206) 783-4520, Crisis Line: (206) 522-9472
- NW Immigrant Rights Project, Seattle, WA. Office: 206-587-4009, Crisis Line: 206-957-8621
- NW Network of Bisexual, Trans, Lesbian & Gay Survivors of Abuse, Seattle, WA. Office: (206) 568-7777
- Multi-Communities, Seattle, WA. Office: (206) 937-7155
- Refugee Women's Alliance, Seattle, WA. Office: (206) 721-0243, Crisis Line: (206) 721-0243
- Salvation Army-Catherine Booth House, Seattle, WA. Crisis Line: (206) 324-4943
- Salvation Army Domestic Violence Programs, Seattle, WA. Office: (206) 447-9944
- Salvation Army-Hickman House Transitional Housing, Seattle, WA. Office: (206) 932-5341
- Seattle Indian Health Board, Seattle, WA. Office: (206) 324-9360
- Solid Ground – Broadview Emergency Shelter and Transitional Housing Program, Seattle, WA. Office: (206) 299-2500, Crisis Line: (206) 299-2500
- YWCA of Seattle/King/Snohomish, Seattle, WA. Office: (206) 490-4353, Crisis Line: (206) 461-4882

East King County

- LifeWire, Bellevue, WA. Office: (425) 562-8840, Crisis Line: (425) 746-1940

South King County

- Domestic Abuse Women's Network (DAWN), Kent, WA. Office: (253) 893-1600, Crisis Line: (425) 656-7867
- Jennifer Beach Foundation, Covington, WA. Office: (206) 833-5366
- YWCA of South King County, Renton, WA. Office: (425) 226-1266

Kitsap County

- YWCA of Kitsap County-ALIVE Program, Bremerton, WA. Office: (360) 479-0522, Crisis Line: (800) 500-5513

Kittitas County

- Abuse, Support & Prevention Education Now (ASPEN), Ellensburg, WA. Office: (509) 925-9384

Klickitat County

- Programs for Peaceful Living, Bingen, WA. White Salmon Office: 509-493-1533, Goldendale Office: 509-773-6100, Crisis Line: (800) 352-5541

Lewis County

- Human Response Network, Chehalis, WA. Office: (360) 748-6601

Lincoln County

- Family Resource Center, Davenport, WA. Office: (509) 725-4358, Crisis Line: (509) 725-4360

Mason County

- Turning Pointe, Shelton, WA. Office: (360) 426-1216, Crisis Line: (360) 432-1212

Okanogan County

- Room One, Twisp, WA. Office: (509) 997-2050, Crisis Line: (509) 997-2050
- The Support Center, Omak, WA. Office: (509) 826-3221, Crisis Line: (888) 826-3221

Pacific County

- Crisis Support Network, Raymond, WA. Office: (360) 875-6702, Crisis Line: (800) 435-7276

Pend Oreille County

- Kalispel Tribe Victim Assistance Services, Usk, WA. Office: (509) 445-1664, Crisis Line: (877) 700-7175
- Pend Oreille Crime Victim Services, Newport, WA. Office: (509) 447-2274, Crisis Line: (509) 447-5483

Pierce County

- Crystal Judson Family Justice Center, Tacoma, WA. Office: (253) 798-4166, Crisis Line: (253) 798-4310
- Eatonville Family Agency, Eatonville, WA. Office: (360) 832-6805
- Puyallup Tribe of Indians – Community DV Advocacy Program, Puyallup, WA. Office: (253) 680-5499, Crisis Line: (253) 680-5499
- Tacoma Community House Client Advocacy Services, Tacoma, WA. Office: (253) 383-3951
- Korean Women's Association, Tacoma, WA. Office: (253) 535-4202, Crisis Line: (253) 535-4202
- YWCA of Pierce County, Tacoma, WA. Office: (253) 272-4181, Crisis Line: (253) 383-2593

San Juan County

- SAFE San Juans, Eastsound, WA
    - Lopez Island, Office: (360) 468-3788, Crisis Line: (360) 468-4567
    - Orcas Island, Office: (360) 376-5979, Crisis Line: (360) 376-1234
    - San Juan Island, Office: (360) 378-8680, Crisis Line: (360) 378-2345

Skagit County

- Skagit Domestic Violence & Sexual Assault Services, Mount Vernon, WA. Office: (360) 336-9591, Crisis Line: (888) 336-9591

Skamania County

- Skamania County Council on Domestic Violence & Sexual Assault, Stevenson, WA. Office: (509) 427-4210, Crisis Line: (877) 427-4210

Snohomish County

- Domestic Violence Services of Snohomish County, Everett, WA. Office: (425) 259-2827, Crisis Line: (425) 252-2873
- Tulalip Indian Tribe – Legacy of Healing Advocacy Center and Safe House, Tulalip, WA. Office: (360) 714-4400

Spokane County

- Abuse Recovery Ministry and Services, Spokane, WA. Office: (509) 484-0600
- YWCA – Alternatives to Domestic Violence, Spokane, WA. Office: (509) 789-9297, Crisis Line: (509) 326-2255

Stevens County

- Rural Resources Victim Services, Colville, WA. Office: (509) 684-3796, Crisis Line: (509) 684-6139 or 844-509-SAFE (7233)
- Spokane Indian Tribe – Family Violence Program, Wellpinit, WA. Office: (509) 258-7502

Thurston County

- Chehalis Confederated Tribes DV Program, Oakville, WA. Office: (360) 273-5911
- Eatonville Family Agency, Eatonville, WA. Office: (360) 832-6805
- SafePlace, Olympia, WA. Office: (360) 786-8754, Crisis Line: (360) 754-6300
- Thurston County Family Justice Center – The Family Support Center, Olympia, WA. Office: (360) 754-9297

Wahkiakum County

- Charlotte House/St. James Domestic Violence Program, Cathlamet, WA. Office: (360) 795-8612, Crisis Line: (360) 795-6400

Walla Wall County

- YWCA-Walla Walla, Walla Walla, WA. Office: (509) 525-2570, Crisis Line: (509) 529-9922

Whatcom County

- Community to Community, Bellingham , WA. Office: (360) 738-0893
- Dorothy Place (a part of Opportunity Council), Bellingham, WA. Office: (360) 734-5121
- Lummi Victims of Crime, Bellingham, WA. Office: (360) 384-2285

- Domestic Violence & Sexual Assault Services of Whatcom County, Bellingham, WA. Office: (360) 671-5714, Crisis Line: (360) 715-1563

Whitman County

- Alternatives to Violence of the Palouse, Pullman, WA. Office: (509) 332-0552, Crisis Line: (509) 332-4357

Yakima County

- Lower Valley Crisis & Support Services, Sunnyside, WA. Office: (509) 837-6689, Crisis Line: (509) 837-6689
- NW Immigrant Rights Project, Granger, WA. Office: (509) 854-2100, Crisis Line: (888) 756-3641
- YWCA-Family Crisis Program, Yakima, WA. Office: (509) 248-7796, Crisis Line: (509) 248-7796

Appendix G: WAC 388-60A: Cognitive Behavioral Therapy Features

The following sections of WAC 388-60A (highlighted) demonstrate the prevalence of the cognitive behavioral approach that is embedded in the WAC standards.

WAC 388-60A-0405 Treatment planning—What must the treatment plan include and when must it be updated? Each program certified for any level of domestic violence intervention treatment must adhere to the following treatment planning standards:

(5) The treatment plan must:
(a) Adequately and appropriately address any criminogenic needs, as well as high risk, critical, and acute factors of the individual participant;
(b) Identify the program's general responsivity by documenting the evidence-based or promising treatment modality the program will use to address the participant's risks and needs in order to assist them in meeting their goals or objectives;
(c) Identify the program's specific responsivity, taking into account the participant's characteristics such as their strengths, learning style, personality, motivation, bio-social factors, and culture;
(d) Include individualized goals or objectives which are behaviorally specific and measurable;
(e) Document required referrals to other treatments or classes such as mental health, substance use, or parenting, which are necessary in order for the participant to be successful in domestic violence intervention treatment;
(f) Document recommended referrals to other treatment programs and resources; and
(g) Document which treatment gets priority and the sequence of treatment for the participant if more than one treatment service is indicated on the plan; and
(6) The treatment plan must be updated when indicated by: (a) Significant changes in the participant's behavior or circumstances;

(b) Factors associated with victim safety;
(c) A change in the participant's treatment risks, needs, goals, or objectives; or
(d) If the participant is moving to a higher or lower level of treatment.

WAC 388-60A-0415 Required cognitive and behavioral changes— Depending on their level of treatment, what changes must the program document that the participant has made?
(1) For levels one, two and three treatment, the program must ensure:

(a) The groups are facilitated by a program staff member who is designated by the department at the staff or supervisor level; (b) A trainee may co-facilitate with a staff or supervisor, but must not facilitate the group alone at any time;

(c) The program uses evidence-based or promising practices (see WAC 388-60A-0310) to facilitate the areas of treatment focus listed in this section;
(d) The cognitive and behavioral changes in this section are the minimum standard for certified domestic violence intervention treatment and the program must add topics, discussions, lessons, exercises, or assignments that meet the individual treatment needs of the participant;
(e) The areas of treatment in this section include cognitive and behavioral changes, which must be shared in treatment by the participant and documented by the program in the participant's individual record as those changes are identified;
(f) Each treatment program certified for levels one, two, and three domestic violence intervention treatment must document in each participant's file that the following cognitive and behavioral changes are documented for each participant and at a minimum include:
(i) **Types of abuse**: Individual and specific examples of how the participant has acknowledged that they have engaged in any abusive behaviors including but not limited to the following types of abuse: (A) Physical;

(B) Emotional and psychological including terrorizing someone or threatening them; (C) Verbal;

(D) Spiritual;
(E) Cultural;
(F) Sexual;
(G) Economic;
(H) Physical force against property or pets;
(I) Stalking;
(J) Acts that put the safety of partners, children, pets, other family members, or friends at risk; and (K) Electronic, online, and social media;
(ii) **Belief systems**: Exploration of the participant's individual and cultural belief system, including acknowledgement of how those beliefs have allowed and supported violence against an intimate partner including privilege or oppression;

(A) Specific examples of how the participant's individual belief system has allowed or supported the use or threat of violence to establish power and control over an intimate partner; and (B) Examples of how the participant has experienced societal approval

and support for control through violence and the designation of an intimate partner or children as safe targets for this violence;

(iii) **Respectful relationships**: Documentation of new skills the participant has gained through exercises in learning and practicing respectful relationship skills including techniques to be nonabusive and non-controlling that include but are not limited to: (A) Requesting and obtaining affirmative consent as an essential aspect of interpersonal relationships; and

(B) Respecting boundaries about others' bodies, possessions, and actions;

(iv) **Children**: Documentation of the participant's understanding of how children have been impacted by the participant's abuse and the incompatibility of domestic violence and abuse with responsible parenting including but not limited to:

(A) An understanding of the emotional impacts of domestic violence on children;
(B) An understanding of the long-term consequences that exposure to incidents of domestic violence may have on children; and
(C) The behavioral changes the participant has made and shared with the group as a result of this understanding; (v) **Accountability**: Documentation of the participant's understanding of accountability for their abusive behaviors and their resulting behavioral changes including but not limited to: (A) Documentation of the participant's understanding of how they are solely responsible for their abusive and controlling behavior and how they acknowledge this fact;
(B) An understanding of the need to avoid blaming the victim and the ability to consistently take responsibility for the participant's abusive behavior, including holding themselves and others in group accountable for their behavior;
(C) Documentation of a minimum of three separate individual examples of how the participant has taken accountability since beginning domestic violence intervention treatment which must be kept in the participant's file;
(D) Documented examples of how the participant has demonstrated spontaneous accountability in treatment, taking accountability in the moment;
(E) Documentation of the participant's accountability plan: (I) The treatment program may assist the participant in developing the plan;
(II) In the plan the participant must make a commitment to giving up power and control, including abusive and controlling behaviors towards the victim and others;
(III) In the plan the participant must take accountability for specific abusive behaviors they have committed and have a plan for stopping all abusive behaviors;
(IV) In the plan the participant must identify examples of individualized and specific behavioral changes they have made which demonstrate an understanding of

accountability; and (V) In the plan the participant must identify their personal motivations, ethics, and values as they relate to maintaining healthy relationships; and (F) Documentation that the participant has demonstrated an understanding of accountability in their past and current relationships, and their progress in taking accountability

including the resulting cognitive and behavioral changes during treatment;

(vi) **Financial and legal obligations**: Documentation of the participant's understanding of why it is necessary for them to meet their financial and legal obligations to family members and the actions they are taking to meet those obligations;

(vii) **Empathy**: Documentation of the exercises or assignments on empathy building that demonstrate the participant's cognitive and behavioral changes as a result of increasing their empathy; (viii) **Defense mechanisms**: Documentation of what the participant has identified as their individual defense mechanisms such as projection, denial, and detachment as well as healthy coping strategies the participant has learned, and the cognitive and behavioral changes they have made in dealing with unpleasant feelings;

(ix) **Self-care**: Documentation of individualized self-care practices the participant has learned and incorporated into their lives, and documentation of their understanding of why self-care is crucial for healthy relationships;

(x) **Support system**: Documentation of the participant's healthy support system, including who they have identified as part of that system and how they provide healthy support;

(xi) **Indicators**: Documentation of the indicators or red flags the participant has identified that they have engaged in, their understanding of how those behaviors are abusive, and the cognitive and behavioral changes they have made as a result; (xii) **Cognitive distortions**: Documentation of the cognitive distortions or thinking errors the participant has identified, that they have used to justify their abusive behaviors, and how they have learned to reframe and change their thinking when those cognitive distortions are present;

(xiii) **Personal motivations**: Documentation of the participant's personal motivations for abusive behaviors and the cognitive and behavioral changes they have made to replace those beliefs and subsequent behaviors which include but are not limited to:

(A) A sense of entitlement;
(B) A belief that the participant should have power and control over their partner;
(C) Learned experience that abuse can get the participant what they want;
(D) The need to be right or win at all costs; and
(E) Insecurity and fear;

(xiv) **Relationship history**: Documentation of the participant's relationship history which documents common characteristics, motivations for abuse, applicable cognitive distortions, and indicators of domestic violence throughout the participant's history of intimate relationships;

(A) The treatment program and group may assist the participant in developing the relationship history; and
(B) The relationship history must focus on the participant's behaviors in an accountable manner without blaming others; and (xv) **Criminogenic needs**: Documentation of treatment in group or individual sessions with level three participants that addresses their individual criminogenic needs as indicated through assessment and treatment planning.

WAC 388-60A-0430 Completion criteria and core competencies—What must the program document for a participant to be eligible to successfully complete treatment?
(1) The program must ensure:

(a) The participant has met the program's written criteria for satisfactory completion of treatment including: (i) Cooperation with all program rules and requirements; (ii) The goals or objectives of the participant's treatment plan, which include measurable behavioral changes; and (iii) The minimum treatment period and requirements; (b) The participant has attended and complied with all other treatment sessions required by the program, which may include ancillary treatments or classes such as mental health, substance use, or parenting;

(c) The participant is in compliance with all related court orders; (d) When a participant who is court ordered to pay spousal or child support is behind on payments, they must show a payment plan agreement and documentation that they have been in compliance with the plan for a minimum of six months, in order to be in compliance; and

(e) Documentation of all cognitive and behavioral changes as required through coverage of the treatment topics, the completion of all assignments, and the requirements as outlined in the level of treatment in which they participated.

(2) In order to complete levels one, two, or three treatment the program must also document the participant has successfully demonstrated core competencies:

(a) Accountability and adherence to the participant's accountability plan;
(b) Increased victim safety as evidenced by written documentation of the participant's demonstration of a change in their beliefs which have resulted in the

participant's cessation of all violent acts or threats of violence for a minimum of the last six months; and

(c) Knowledge of their personal primary motivations for abusive or controlling behaviors and alternative ways to meet their needs in a non-abusive manner.