A Process Analysis of Maryland Abuser Intervention Treatment Programs' (AIP) Policies and Guidelines

Dr. Tara Richards
Assistant Professor
School of Criminal Justice
University of Baltimore
1420 North Charles Street, LAP519
Baltimore, MD 21201
PH: 410-837-6087
EMAIL: trichards@ubalt.edu

Dr. Christopher Murphy
Professor and Chair
Department of Psychology
University of Maryland, Baltimore County
1000 Hilltop Circle
Baltimore, MD 21250
PH: 410-455-2367
EMAIL: chmurphy@umbc.edu

Executive Summary

Abuser Intervention Programs (AIPs) are the primary response to domestic violence offenders in the state of Maryland. Although the Governor's Family Violence Council's Operational Guidelines for Abuser Intervention Programs in Maryland provide "minimal operating standards," very little is currently known regarding what individual AIPs *are actually doing*. Without such information, it is very difficult to advance best practices for MD AIPs or to test the effectiveness of either individual AIPs or MD AIPs in general. In keeping with the GOCCP's priority to advance "evidenced-based recidivism reduction programs that, deliver services to and enhance successful outcomes for, ex-offenders in communities throughout Maryland," we completed a process analysis of MD AIPs using a representative sample of programs receiving court referrals across the state. Specifically, this research examined AIP's (1) processes and content, (2) philosophies and goals, (3) relationships with referral and monitoring organizations, and (4) familiarity and compliance with state guidelines. The project identifies challenges and promising practices regarding AIP service delivery in Maryland, and provides a foundational knowledge base to support future research on program effectiveness (i.e., the association between program completion and future recidivism) that can be used to design future studies of program efficacy.

In order to meet these goals, all certified Maryland AIPs (n=32) were asked to volunteer to participate in the study; 20 AIPs (63%) volunteered to participate and were enrolled. The AIP sample was quite diverse in that participating AIPs serve 18 Maryland counties ranging from urban Baltimore City and Prince George's counties to more rural Caroline and Kent counties. The majority of AIPs had been in operation for more than 15 years (75%), with fewer AIPs reporting they had been in operation for 3-5 years (20%) or less than one year (5%). Participating AIPs reported employing between 1 and 8 AIP group facilitators (M=3, SD=2) and between 0 and 9 other direct service staff (M=2, SD=2). AIP program length varied from 20 weeks to 40 weeks in length (M=26, SD=4). Programs reported that between 60% and 100% of clients were court mandated to treatment (M=92%, SD=9%) and that between 30% and 97% of program participants successfully complete the program (M=73%, SD=19%).

Data collection involved: a) review of program materials; b) structured telephone interviews (approximately 1 hour) with 2 program staff; and c) review of 5 de-identified case files for each program. To begin, we obtained the most recent AIP program materials submitted to GOCCP as part of the AIP's certification. Then, we completed AIP staff interviews with one AIP treatment provider who works directly with AIP clients and one staff person who serves in an administrative capacity at the AIP (e.g., the AIP program director or executive who oversees the AIP program). For two programs, there was only one AIP staff person who served as both the group facilitator and the program administrator, and as such, only one interview was completed for the program. A total of 38 staff participants were interviewed. Staff participants were primarily White (62%), African American (26%), or Hispanic/Latino (8%). Finally, research team members examined 5 de-identified client case files for each AIP; case files included 2 active client files for clients who have completed at least 4 treatment sessions and 3 closed files for clients who satisfactorily completed the program. Data were collected using a file checklist and organized using qualitative data management software. Content analysis identified themes within and across AIPs relevant to the study's research questions. Content analysis requires

careful consideration of data to link codes with words or passages within the text in order to explore overarching themes and patterns (Berg, 2004).

Several key recommendations emerged from this process analysis of Maryland AIP practice:

1) Providers consistently conveyed the importance of several key elements of AIP practice, including: a) the need for effective strategies to address participants' initial resistance (to reduce minimization and blaming and enhance accountability and change motivation) b) the importance of establishing a collaborative relationship with AIP participants to achieve program goals, and c) the value of positive group interactions (including role modeling) to promote change. All of these insights are consistent with available research on AIP efficacy. However, there is also considerable variation in how Maryland AIPs approach these key areas of practice, highlighting: a) the need to apply currently available research findings and to conduct further research to clarify best practices for motivating participants to change, establishing collaborative relationships, and facilitating effective group interactions; and b) the development and use of effective methods to disseminate these best practices.

2) Providers conveyed many possible change targets for AIP work, and had divergent views on the value of structured program materials. Given that: a) behavior change efforts are typically enhanced through practice and application between counseling sessions, and b) some AIP providers expressed considerable enthusiasm about their use of structured program materials, important next steps to promote best practices may involve efforts to gather and/or create resource materials to promote structured program interventions that address the key change targets identified by AIP providers.

3) Providers differ substantially in their efforts to evaluate and address individual problems that may influence the effectiveness of AIP services. Key examples include substance use disorders, serious mental health concerns (e.g., psychotic and mood disorders), traumatic stress reactions, and life complications such as unemployment and housing instability. The available research indicates that such factors are often associated with increased risk for violence recidivism, and therefore movement toward best practice will require increased responsiveness to individual needs and risk profiles. These efforts may be facilitated by organizing resource materials and providing training to help AIPs assess key individual problems and risk factors in an accurate and efficient fashion, and by developing and disseminating effective strategies to reduce violence risk linked to individual problems (e.g., substance abuse, mental health problems) that may not be sufficiently addressed within standard AIP practice.

4) Providers indicated that there was substantial need for evaluation regarding the association between AIP completion and future recidivism. Although some providers reported using the number of repeat clients as an indicator of program effectiveness, most providers readily admitted that there was a lack of understanding regarding the impact of their program on behavioral change among their clients, especially over time.

5) The level of financial and infrastructure support for Maryland AIPs is woefully inadequate to promote full implementation of best practices. Resource limitations affect many key aspects of AIP practice, including Programs' ability to recruit, train, and retain AIP staff; their capacity to assist low-income AIP participants; and their ability to provide timely services following best practice models (e.g., maintaining manageable group sizes, offering accessible services in rural communities; addressing co-occurring problems with mental health and substance abuse, etc.). This situation reflects broader societal trends in which endemic public health problems associated with violence receive less attention and resources than acute epidemic public health problems (such as Zika, Ebola, etc.) that affect far fewer individuals and have much less overall negative influence on public welfare. AIP collaborative groups, such as the Governor's Family Violence Council certification workgroup and MAIC, should enhance relationships with Maryland legislator's to craft legislation to increase state funding and/or apply for federal funding streams targeting offender rehabilitation and recidivism reduction such as Justice Reinvestment Grant funds. Without increased resources, efforts to enhance best practices at Maryland AIPs are likely to produce only modest and inconsistent results in enhancing public safety.

6) AIP coordination with referring sources is highly variable and is an important area for program practice enhancement. Our analysis uncovered some exemplary models to support effective communication and careful monitoring of referrals and compliance. Individual AIPs should consider the viability of such models for their program/jurisdiction and consider adopting such innovations or modifying innovations to improve their program practice. Improving practice in this area is likely to reduce the number of high-risk cases that are noncompliant with AIP services and avoid legal consequences of noncompliance. Research has indicated that greater coordination of the community response to IPV is likely to reduce violence recidivism.

7) Limited training and credentialing options serve as a significant barrier to AIP work. AIP staff who are geographically isolated in less populated areas of Maryland face intense challenges in traveling to multi-day trainings which require monetary support and work absence. Further, training is offered infrequently, which becomes problematic when staff are hired mid-year and must wait months until they can complete the necessary training. The AIP Certification Workgroup is encouraged to increase the frequency and accessibility of training, and to develop alternative delivery options such as on-line streaming presentations and/or webinars. Utilizing such technology will reduce travel time and cost for trainees and trainers and support increased frequency of trainings.

Introduction

Abuser Intervention Programs (AIPs) are the primary response to domestic violence offenders in the state of Maryland. While the Governor's Family Violence Council's (GFVC) Operational Guidelines for Abuser Intervention Programs in Maryland provide "minimal operating standards," very little is currently known regarding what individual AIPs *are actually doing*. Without such information, it is very difficult to advance best practices for MD AIPs or to test the effectiveness of either individual AIPs or MD AIPs in general. In keeping with Governor's Office of Crime Control and Prevention's (GOCCP) priority to advance "evidenced-based recidivism reduction programs that, deliver services to and enhance successful outcomes for, ex-offenders in communities throughout Maryland," we completed a process analysis of Maryland AIPs using a representative sample of programs receiving court referrals across the state. Specifically, this research examined AIP's (1) processes and content, (2) philosophies and goals, (3) relationships with referral and monitoring organizations, and (4) familiarity and compliance with state guidelines. The project identifies challenges and promising practices regarding AIP service delivery in Maryland, and provides a foundational knowledge base to support future research on program effectiveness (i.e., the association between program completion and future recidivism).

Project Background

Domestic violence (DV) is a major public health and safety issue in Maryland. In 2014, there were 27,242 domestic violence crimes[1] reported in Maryland, including 24,485 assaults (Maryland Uniform Crime Reporting (UCR) Program, 2015). Given that criminological research

[1] Under the Maryland UCR Program, the definition for a domestically related crime mirrors HB1146/SB647: "any crime committed by a suspect (respondent) against a victim who is a person eligible for relief, as defined in §4-501 of the Family Law Article or who had a sexual relationship with the suspect within 12 months before the commission of the crime. This also includes homosexual relationships." A "person eligible for relief", as defined in §4-501 of the Family Law Article includes: (1) The current or former spouse of the respondent; (2) A cohabitant of the respondent";(3) A person related to the respondent by blood, marriage, or adoption; (4) A parent, stepparent, child, or stepchild of the respondent or the person eligible for relief who resides or resided with the respondent or person eligible for relief for at least 90 days within 1 year before the filing of the petition; (5) A vulnerable adult; (6) An individual who has a child in common with the respondent.

demonstrates that domestic violence is severely underreported to police (Felson & Pare, 2005), the number of DV crimes in Maryland is likely much higher. Further, from 2013 to 2014, there were *42 DV related deaths* in the state (Maryland Network Against Domestic Violence, 2016). Court mandated treatment programs are one of the primary responses to domestic violence offenders in the United States with research estimating that approximately half a million men engage in AIPs each year in more than 2,500 programs nationwide (Boal & Mankowski, 2014). In Maryland, 32 Governor's Family Violence Council certified AIPs (GFVC, 2015), in addition to other uncertified programs, are tasked with reducing domestic violence recidivism among the state's domestic violence offenders. At the same time, very little is currently known regarding what individual AIPs in Maryland are actually doing, including their program philosophies and practices, the challenges they face in completing this work, the nature of their relationships with referral sources and other providers, and how they interface with existing practice guidelines. The limited state of knowledge regarding these program elements and practices make it difficult to identify areas for program improvement or to conduct meaningful and interpretable tests of the effectiveness of individual AIPs or MD AIPs in general.

In the 1980s "standards" for Abuser Intervention Program operation were introduced, and as of 2014, 45 states and the District of Columbia had adopted at least some state AIP guidelines (Babcock et al., in press; Maiuro & Eberle, 2008). In Maryland specifically, in 1995 the Post-Disposition Committee of the newly formed Maryland Family Violence Council (MFVC) took up the issue of Abuser Intervention Program (AIP) standards. After considerable debate, the committee decided not to follow the pattern of many other states, which had developed extensive program requirements in the absence of any research evidence to support these standards. The committee opted instead to forge consensus around several general operating guidelines deemed

important for promoting offender accountability and victim safety. Certified programs were required to focus directly on stopping abuse, to maintain effective communication with courts and referring agencies, and to conduct victim outreach, maintain victim confidentiality, and provide victims with information about the abusive individual's program attendance (Maryland Family Violence Council, 1996). The guidelines also provided standard definitions of abusive behavior, required screening and referral for substance abuse and mental health problems, and stipulated the need for culturally sensitive and violence-free staff. The committee deliberations were informed by a 1996 report from the American Psychological Association Presidential Task Force on Violence and the Family, which urged caution in providing only one form of standard batterer treatment and promoted the need to have a range of treatment options available for domestic violence offenders. The MFVC established a program self-certification process, and established the Maryland Abuser Intervention Collaborative (MAIC) with the goal of bringing researchers and program practitioners together to conduct and utilize empirical research to develop standards and promote best practices for Maryland AIPs.

Project Objectives

During the funded project year, the research team completed the following objectives to realize the project goals:

1) Developed logic models of Abuser Intervention Programming in Maryland by:
    a) Describing the range of intervention models used by Maryland AIPs
    b) Identifying proximal (short-term) change targets that program practitioners believe contribute to long-term cessation of partner violence in Maryland AIPs
2) Identified promising practices used by Maryland AIPs by:
    a) Uncovering program staff perspectives and ideas about program elements and program

practices that are considered to be important and effective in ending IPV

b) Conducting a systematic analysis of common and unique AIP program practices and comparing them to empirical research on commonly accepted principles of behavior change and offender rehabilitation

3) Characterized challenges and barriers to effective practice across Maryland AIPs by:

a) Uncovering program staff perspectives on the challenges they face in conducting this work

b) Elucidating the working relationships of Maryland AIPs with local legal systems, referral sources, and service providers

4) Identified ways in which the Maryland AIP Guidelines can facilitate and promote best practices by:

a) Identifying program staff awareness of the Guidelines

b) Uncovering program staff perspectives on helpful and facilitative aspects of the Guidelines; and

c) Uncovering program staff perspectives on the challenges posed by compliance with the Guidelines and suggested changes.

Methodology

Sample

Abuser Intervention Program Sample

All certified Maryland AIPs (n=32) were asked to volunteer to participate in the study; 20 AIPs (63%) volunteered to participate and were enrolled in the study. Participating AIPs served 19 Maryland counties: Allegany, Anne Arundel, Baltimore, Baltimore City, Calvert, Caroline, Carroll, Charles, Dorchester, Harford, Howard, Frederick, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Talbot, and Washington counties. The majority of participating AIPs

had been in operation for more than 15 years (75%), with fewer AIPs reporting they had been in operation for 3-5 years (20%) or less than one year (5%). Participating AIPs reported employing between 1 and 8 AIP group facilitators (M=3, SD=2) and between 0 and 9 other direct service staff (M=2, SD=2). AIP program length varied from 20 weeks to 40 weeks in length (M=26, SD=4). Programs reported that between 60% and 100% of clients were court mandated to treatment (M=92%, SD=9%) and estimated that between 30% and 97% of their program participants successfully complete the program (M=73%, SD=19%).

Abuser Intervention Program Staff Sample

For each of the 20 participating AIP programs, we requested that two AIP staff participants, one AIP treatment provider who works directly with AIP clients and one staff person who serves in an administrative capacity at the AIP (e.g., the AIP program director or executive who oversees the AIP program), complete a telephone interview with a research team member. For two programs, there was only one AIP staff person who served as both the group facilitator and the program administrator, and as such, only one interview was completed for the program. The total sample of staff participants included n=38. The sample was fairly racially/ethnically diverse, with staff reporting their race/ethnicity as White (63%), African American (24%), Hispanic (8%), and Bi-racial (3%)[2]. Regarding education, 82% of staff participants indicated that they held a LCSW and 10.5% indicated holding a Bachelor's degree. Staff participants reported from 1 to 25 years (M=9, SD=7) of experience working with domestic violence offenders.

[2] 3% of staff participants preferred not to report their race/ethnicity.

Data Collection

Data collection involved: a) review of program materials; b) structured telephone interviews (approximately 1 hour) with 2 program staff; and c) review of 5 de-identified case files for each program. To begin, we obtained the most recent AIP program materials submitted to GOCCP as part of the AIP's certification. Programs materials included a standardized "Application for Certified Compliance with Maryland Guidelines for Abuser Intervention" which yielded a wealth of background information about each program, as well as forms and materials used with program clients. We also solicited participating programs to submit any new or additional program materials to us directly. Next, we completed interviews with AIP staff members (see Appendix A for interview script). Interviews lasted approximately one hour. The interviews were recorded and then later transcribed by a research team member. All responses were de-identified upon transcription and audio files were destroyed. Finally, in order to triangulate the information we collected from the document reviews and interviews, we completed reviews of 5 de-identified client case files for each AIP. Case files included 2 active client files for clients who have completed at least 4 treatment sessions and 3 closed files for clients who satisfactorily completed the program. Data were collected using a file checklist (see Appendix B for file review checklist); no identifying client information was recorded from the case files.

Project Findings

1) Logic Models of Maryland Abuser Intervention Programs

In characterizing AIP practice in Maryland, we have grouped interview response information using two thematic distinctions that were uncovered upon individual and collective reviews of the interview responses. One is a distinction between structured program content (i.e.,

topics and issues addressed or covered in a relatively consistent fashion within the programs) versus key change targets (i.e., specific program participant changes that interview respondents believe promote long-term cessation of violence and abuse). A second distinction involves the facilitation process, which can include aspects of the client – facilitator relationship, relationships and interactions among clients in group, and specific facilitation / intervention strategies that respondents identify as helpful or useful.

Describe the Range of Intervention Models Used by Maryland AIPs.

In line with the history of Maryland's AIP Guidelines, which refrained from providing highly prescriptive requirements in the absence of clear research support (Murphy, 2002), our interviews uncovered considerable variation in program models, program structure, program philosophy, and intervention goals. Many respondents reported using aspects of several intervention models, and a smaller number indicated that they adhere strictly to one of the standard program curricula available in the field. As revealed in Table 1, the most commonly mentioned model was the Duluth / Power and Control approach (13 respondents) which is the most widely adopted AIP approach nationally (Price & Rosenbaum, 2009). However, only 3 respondents indicated strict adherence to the Duluth curriculum. The EMERGE model, which like Duluth is grounded in a feminist analysis of IPV and emphasizes consciousness raising regarding gender and power, was mentioned by 3 respondents. Other programs models include Wexler's STOP approach, which is grounded in a cognitive-behavioral therapy (CBT) theory of change (4 respondents), and other CBT approaches (5 respondents). In addition, 7 respondents indicated that they integrate aspects of motivational interviewing or a stage-of-change approach in their work. In summary, respondents reported considerable variation in program models, and

the majority of Maryland AIPs report using integrative, eclectic, modified, or customized approaches rather than full adoption of published, standardized curricula.

Table 1: Program Models Informing Maryland AIP Practice

Curricula	Number of total Respondents Reporting Approach	Number of Respondents indicating Primary Approach	Number of Respondents indicating Secondary or Integrated Approach
Duluth Model (Pence & Paymar, 1993)	13	3	10
STOP (Wexler, 2013)	4	4	-
EMERGE (http://www.emergedv.com/)	4	2	2
Stop the Anger Now (Potter-Efron, 2001)	1	-	1
Family Peace Initiative (http://www.familypeaceinitiative.com/)	1	-	1
Motivational Interviewing	3	-	3
Stages of Change	4	1	3
Cognitive – Behavioral Therapy	5	3	2
Dialectical Behavior Therapy	1	-	1
Custom / Own Approach	2	2	-

Program / Practitioner Philosophies. Considerable variation in program and practitioner philosophy was also apparent. One common theme is the importance of holding participants accountable for their abuse and its effects. Example responses include *"This is a chosen behavior … something that they need to take responsibility for"; "My philosophy is … to hold my clients accountable for their actions, to assure that they take full responsibility for their role - why they're in the program.";* and *"We do believe that change is possible, but … we really feel like we have to get people to admit what their responsibility is in their relationship before any of that can happen."*

Related themes include the importance of "*promoting respect versus oppression,"* understanding abuse as a form of control: "*IPV boils down to that - power and control.*"; and broadening the focus of AIP beyond physical violence, for example *"We look at domestic*

violence as being more than physical – we look at it as including intimidation and emotional abuse as well as sexual and even economic abuse."

A number of respondents highlighted the importance of gender-based analyses of IPV, including male socialization … *"They are taught from little boys that they are the man, they should be in charge"* and male privilege… *"Most of the men that come in to us … are using a lot of male privilege."* One respondent noted a shift in practice over time in applying power and control concepts such as the Duluth model, *"There was a little philosophical shift … it's more of a counseling relationship and not so much a correctional kind of approach"* and another reflected on emerging tensions in the use of gender-based analyses:

> *"I think we do still hold the belief that the majority of severe physical abuse is perpetrated by men against women in heterosexual relationships. I know that that has become a complicated or conflictual position, but I still tend to believe that there are a lot of pieces of our culture that prop up male dominance and a lot of perpetrators use that even if they're not fully cognizant"*

In contrast, some respondents placed more emphasis on what may be considered a therapeutic, rather than a social change or consciousness-raising approach, which may include efforts to address a range of problems experienced by AIP participants: *"Our philosophy is encouraging clients to develop healthier relationships and that includes addressing the entire person. That includes substance abuse, treatment referrals for mental health, and any medical needs they might have."* Some respondents highlighted the challenges created by holding IPV offenders accountable for their actions while still providing them with support to promote change, e.g., *"We try not to treat them like offenders only; we try to treat the person as a whole."*

A number of respondents articulated a program philosophy grounded in social-learning theory, which focuses on abuse as learned behavior, e.g., *"to identify their destructive thinking patterns and abusive behaviors … and to unlearn those behaviors and replace them with healthy behaviors."* A similar theme involves a focus on promoting healthy relationships, e.g., "*they can develop new information to challenge belief systems and new behaviors can occur that create healthier relationships."* However, concern was also expressed that this type of focus not limit personal responsibility, e.g., *"IPV is a behavior problem, not a relationship problem."*

Another theme in program philosophy involves the recognition that many abusive individuals have experienced significant life adversities, e.g., *"a lot of these clients have experienced significant trauma,"* however relatively few programs indicated that this awareness is integrated in efforts to promote change, e.g., *"We … explore childhood experiences and the origins of their destructive beliefs."*

Use of Structured Materials vs. Unstructured Process Groups. Programs vary substantially in their reliance on structured program materials, such as homework or practice assignments, handouts, workbooks, and structured group activities. Some respondents reported very positive views of structured program materials, e.g., *"Many of them [AIP clients] actually mention… how much they actually love this manual and that they're going to keep it forever and use it and refer to it; or they've taken things home and shared them with their partners and there's skills that they didn't realize that they didn't know or that they needed to know."*

Interestingly, other respondents conveyed a very different perspective on the utility of homework, for example, *"We seldom do homework, basically because they [clients] won't do it. Years ago we did that. [It's] just too difficult to get them engaged in it. ... They forgot [it], they lost it. When they're out of that class they're gone. So that doesn't work too well."*

Use of multi-stage program models. One developing trend in Maryland AIP practice involves the use of multi-stage group approaches. These typically involve a psychoeducational component in Stage 1. Some multi-stage programs require participants to provide statements indicating acceptance of personal accountability for their abusive behavior, and may require successful performance of this task before allowing participants to graduate to Stage 2. In document reviews from the 2015 certification, 11 of the participating programs for the current project indicated the use of multiple program phases. In the interviews, 7 respondents representing 6 distinct AIPs reported that their programs use a multi-stage model.

Group and individual approaches. In document reviews from the 2015 certifications, all participating programs reported that they provide group interventions. One quarter of programs reported that they rely exclusively on the group format, and 75% of programs indicated that they also provide individual (one-on-one) counseling. However, all available evidence indicates that the individual format is a secondary approach used in a relatively small proportion of cases by Maryland AIPs.

Open versus closed-ended group formats. Open group formats use, "rolling admissions," so that participants within a given group may have completed different numbers of sessions and may be at different points in the change process. Closed group formats have a specific group composition and participants begin and end group together as a cohort. The interview results uncovered variation in approach, with the majority of Maryland AIPs utilizing an open group format. Closed groups are more typically used in research due to the greater ability to specify the content and sequence of interventions. Group cohesion and trust may also be promoted by closed group membership. However, open groups have important practical advantages, including decreased wait time (i.e., delays in gathering enough participants to start a new group), and

greater efficiency from filling available slots when participants complete or drop out. Several respondents also mentioned the value of having more experienced group members address newer group members' concerns and serve as role models for change.

Program Content Focus. The vast majority of Maryland AIPs are psychoeducational in nature or include a psychoeducational component. Most interview respondents described one or more areas of program content focus for psychoeducation and behavior change. A list of program content areas reported by respondents is presented in Table 2.

Not surprisingly, many respondents reported that they provide education about different forms of abuse, including emotional abuse and expressions of power and control. Other commonly mentioned content areas include accountability; the impact of abuse on victims; helping participants identify high-risk situations and personal triggers for abuse; and providing safety strategies for managing high-risk situations. Many programs also provide psychoeducation about healthy relationships and communication skills.

Reflecting trends in the broader field, programs appear to differ in their emphasis on promoting social change through raising participants' consciousness regarding their use of power and control versus enhancing participants' emotional and mental health. Several providers describe a program focus on gender-based themes involving masculinity, attitudes about women, and cultural influences that promote male dominance. This emphasis may also include adaptations for specific populations, such as discussions of community histories of oppression. Other providers reported more focus on participants' personal concerns such as histories of childhood adversity and abuse, mental health difficulties, emotional awareness, distress tolerance, and stress management. Other areas of program content mentioned by providers

include motivation or stages of change, parenting and co-parenting, and the connection between substance use and partner abuse.

Table 2: Program Content Focus Areas Identified by Maryland AIP Providers

Content Focus	Notes
Education about forms of abuse	e.g., power and control wheel
High risk situations / personal triggers	
Accountability / victim impact	e.g., personal written statements describing abuse
Emotional awareness	
Anger / anger management	Includes difference between anger and abuse
Communication skills	e.g., active listening, emotional expression
Problem solving	
Distress tolerance	
Healthy relationships	e.g., trust, respect
Time Out / personal safety plan	
Societal / cultural beliefs linked to IPV	
Attitudes toward women /masculinity	Includes sexism, rape promoting beliefs
Parenting	
Co-parenting	
Effects of IPV on children	
Childhood / family origins of IPV	
Substance use and abuse	
Participants' history of oppression	
IPV and mental health	
Increasing motivation for change	
Stress / stress management	

Descriptions of the Participant Change Process. Analysis uncovered many similarities in how providers view AIP participants' change process, particularly the early steps toward change. Many providers indicated that abusive clients must first recognize their abusive behaviors, acknowledge the need for change, and stop blaming others*: "So we go from … 'it's not my [clients] fault, it's her [victim] fault' or whoever it is that's against me to contemplating 'there are different decisions I can make' and identifying where they went wrong."* From there, many providers noted the importance of identifying personal goals and reasons for change *"it goes from, 'I have to be here' to 'I want to be here.'"* These early changes may be facilitated by participants' experience of support within the AIP. One provider explained, *"once they [clients] recognize that our job is not an extension of what the court does, we're not there to judge them, we are not there to make them feel bad about themselves … they seem to soften up a little bit. They are more open to doing something different and changing."* One provider described the overall change process very succinctly, *"[the client] has to identify that there's a problem, decide to do something about it, and put in the work to make that change."*

Many providers described the importance of group interactions in the change process, including holding one another accountable, e.g., *"…building that accountability within the group helps them [clients] be successful. Because there's something about having the other members hold them accountable and say 'you know, I really didn't hear the empathy in that statement' or 'no, you're still blaming your partner for that.'"* Fellow group members also provide role modeling and share ideas about how to change, e.g., "*I think that they gain the most and they change when they hear someone else in the room is going through something similar, and the solution that that person has found doesn't have to do with violence*." Several providers commented on how open enrollment groups create opportunities for positive peer interactions,

e.g., "*people who have been there longer in the group sort of take on a mentoring role for people who have been there less time and it's more effective whenever new people hear the people who have been there a longer time give them advice about what they have been doing differently.*"

Identifying proximal (short-term) change targets that program practitioners believe contribute to long-term cessation of partner violence in Maryland AIPs

Key Participant Change Targets for AIP Intervention. There is widespread agreement on the ultimate goal of ending intimate violence and other forms of abuse, and widespread agreement that many AIP participants present initial resistance to change. However, much greater diversity of opinion is present on the specific changes that participants need to make to end their use of violence and abuse. As revealed in Table 3, one of the challenges in standardizing best practices for Maryland AIPs arises from the diverse array of change targets that providers feel may be important in ending abuse. Many providers indicated the importance of helping participants to recognize their abuse, see abuse as more than violence (i.e., control, emotional abuse), take personal responsibility, and stop blaming others and minimizing their abusive actions.

In addition, many providers highlighted the importance of helping participants identify and manage events that led up to abuse, including high-risk situations, personal triggers for acting abusively, and cues, such as internal sensations associated with increasing tension. Likewise, strategies for managing high-risk situations, such as time outs, cool downs, and deep breathing, were identified by a number of providers as key change targets.

Developing healthy communication and understanding healthy relationships was also commonly mentioned, although providers identified a range of different skills related to these change targets. A number of providers indicated that the ability to listen or develop empathy for the partner is a key area for change. Importantly, a number of providers highlighted the

importance of enhancing participants' ability to identify, express, and regulate emotions, both anger as well as other difficult feelings (e.g., jealousy, insecurity). Some providers also mentioned assertiveness skills as a relevant change target for communication.

Several other potential change targets were mentioned less frequently, but are important to point out here. One involves changing attitudes about gender roles, for example reformulating conceptions of masculinity. Another involves identifying and managing stress. Several providers identified the themes of enhanced decision-making and problem solving as important change goals.

No AIP providers reported that they currently assess the impact of change targets (or program content or structure) on AIP client recidivism; however, many providers indicated that they would value outcome assessments. For example one provider noted, *"I think it's a great program. The guys do a great job in terms of facilitators. I do think, as I've identified, we need outcome assessments, more than just anecdotal kinds of things."*

Table 3: Participant Change Targets Identified by AIP Providers

Change Target	Example(s)
Recognize / identify abusive behaviors	Understand various forms of abuse, like using the children, financial restrictions, undermining partner's work success, isolation Acknowledge one's own abusive actions Identify personal use of power and control Recognize cycle of violence
Take responsibility for one's abusive actions	Own what you did and that it is not OK Reduce partner blaming Recognize one's role in situations Realize that there is no excuse for violence / nothing justifies violence No one can make you do these things Can only change yourself Recognize defense mechanisms – denial, minimization, blaming
Recognize and accept the effects of abuse	Stop minimizing the effects of abuse Identify effects on children
Recognize their intentions / goals of acting abusively	To identify healthier ways of accomplishing these goals Distinguish short-term and long-term effects of abusive behaviors
Change beliefs and attitudes about gender roles	Understand power and control and male privilege Understand the equal role of women in society Understand where the sense of permission to act abusively comes from Follow and respect the female co-leader in group Re-conceptualize masculinity as steady, calm, supportive not intimidating and aggressive
Identify triggers and risky situations	Recognize things that lead up to abuse "Red flags" Break down situations and events Identify physical cues (e.g., body tension)
Manage high-risk situations	Remove self from situation Take appropriate time outs Learn cool down and self-calming strategies (e.g., breathing; muscle relaxation) Use distress tolerance to manage triggers
Learn qualities of healthy and unhealthy relationships	Identify health relationships Identify sources of personal beliefs about how relationships work

Increase healthy communication	Listening skills Validation Using more words to express feelings Expressing thoughts, needs, and emotions non-aggressively Use “I” statements
Reduce unhealthy communication	Demanding Interrupting Blaming
Recognize and identify feelings	Identifying feelings other than anger Distinguish thoughts from feelings Learn healthy ways to deal with anger
Enhance emotion regulation	Learn to handle a range of feelings: jealousy, insecurity, anxiety Understanding how beliefs, emotions, and behaviors work together
Increase assertiveness	Understand passive, aggressive, and assertive responses
Increase Empathy	Recognize what the other person is experiencing
Identify and challenge anger-producing thoughts	Unrealistic beliefs / expectations Reduce negative self-talk
Enhance problem solving skills	
Accept criticism without becoming defensive	
Recognize how one’s past learning influences current problems	Understand abuse as learned behavior; how one was raised; witnessing or experiencing abuse in childhood
Self-care	Positive / pleasurable activities
Manage stress	Recognize how stress at work affects relationships Brief meditation exercises
Increase Respect	
Understand sexual consent	
Improve decision making	Choosing partners; how to date; Recognize that you have choices
Self-control	Think before they speak
Self-awareness	

2) Identify promising practices used by Maryland AIPs

Program staff perspectives and ideas about program elements and program practices that are considered to be important and effective in ending IPV. Many providers highlighted the importance of peer interactions and group encouragement as key elements of AIP success. Many also emphasized the importance of building a trusting and supportive relationship between facilitators and participants. The strategies for training and supporting AIP staff to enhance their effectiveness in these areas were not as well articulated, and may currently rely on a unique set of skills possessed by specific providers.

One key area for promising practices at Maryland AIPs may involve the identification and/or development and dissemination of high-quality structured program materials, along with supportive training to promote effective implementation. Much research suggests that individuals are more likely to accomplish behavior change if they work on their problems between sessions and use structured strategies to promote change. However, facilitators often experience serious challenges obtaining buy-in and compliance from AIP participants regarding structured change efforts and associated materials (e.g., homework or practice assignments). The fact that some practitioners provided highly favorable appraisals of their structured program materials indicates that this may be an area for further work and development to promote best practices.

At the same time, no AIP providers reported that their program currently assesses the impact of program elements and/or practices on AIP client recidivism; however, many providers indicated that they would value outcome assessments. For example one provider noted, *"I think it's a great program. The guys do a great job in terms of facilitators. I do think, as I've identified, we need outcome assessments, more than just anecdotal kinds of things."* Outcomes assessments are necessary to confirm that AIPs are meeting their goal of ending IPV.

Systematic analysis of common and unique AIP program practices and comparisons to empirical research on commonly accepted principles of behavior change and offender rehabilitation. Bonta and Andrew's model of offender rehabilitative counseling has had substantial influence on forensic practice in the U.S. and Canada. This model indicates that effective programs are sensitive and responsive to participants' unique risk factors. Effective rehabilitation programs provide interventions that are responsive to the individual's "criminogenic needs" (factors related to criminality such as substance abuse, antisocial attitudes, etc.) and address the reasons why the individual engages in criminal offending (Bonta & Andrews, 2007). Our process analysis of Maryland AIP practice reveals several challenges and barriers to providing AIP services in line with this overarching model.

One challenge arises from the wide array of potential client change targets identified in light of program limitations in funding, staffing, space, and other resources (see discussion of AIP challenges below). In response, providers may experience pressures to address a variety of risk factors and personal difficulties experienced by AIP participants, but may by unable to provide interventions that are sufficient to address each individual's specific problems. For example, the link between substance abuse and domestic violence is clear. A study of over 800 participants from several AIPs around the country found that men who drink to intoxication were 3-4 times more likely to engage in repeat violence than those who don't consume alcohol, and men who are drunk nearly every day are 16 times more likely to engage in repeat violence (Gondolf, 1999). However, offering one or two group sessions focused on the links between substance abuse and violence may be irrelevant for participants who don't use substances and inadequate for those who have significant substance use problems.

Similar concerns can be raised regarding efforts to include one or two sessions on parenting and co-parenting concerns, stress and coping, or a number of other potentially important change targets. These challenges are heighted by resource constraints on staffing, space, etc., including the size of groups and duration of group sessions. Such constraints make it very difficult to engage all AIP participants in an intensive change process or to address unique risk factors for specific participants.

The countervailing tendency is to assume that all AIP participants have relatively homogenous risk factors and needs. This perspective is supported by the relatively consistent view of the change process reported by many Maryland AIP providers, most notably the importance of getting past initial partner blaming and denial of responsibility. Interestingly, there appear to be several distinct approaches to these initial challenges, raising important questions for further research and analysis of best practices. Some programs address initial resistance through specific accountability exercises, which require participants to articulate their own abusive actions and the effects these have had on other people. Other providers rely on supportive counseling strategies to build collaboration and help participants to articulate personal motivations to change and resolve their ambivalence about the need for change. Many providers indicated that other AIP participants play an important role in that process, which may be influenced by how groups are structured (e.g., multi-stage programs, open versus closed groups), and by group facilitation skills.

One apparent result of these inherent challenges is that many providers found it somewhat difficult to articulate their philosophy and approach to AIP work, including the specific change targets that they believe are most important for long-term cessation of violence and abuse. The use of eclectic intervention strategies derived from diverse conceptual models, or

relatively unstructured approaches that are responsive to the specific concerns raised by AIP participants during each session, are not inherently problematic, and undoubtedly reflect the complexity and challenge of AIP work. However, as program approaches become more fluid and less consistently organized around core practices and themes, a greater premium is placed on the counselor's unique skill set and ability to effectively address a wide array of issues that emerge spontaneously during AIP sessions. In addition, a high degree of program flexibility creates challenges for specifying best practices and evaluating whether programs are delivering AIP services in a consistent and reliable fashion. Our process analysis reveals a need for program models and provider training approaches that will allow AIP practitioners to establish strong collaborative working relationships with AIP participants and to respond creatively and sensitively to their needs while also ensuring consistent attention to key elements of the assessment and intervention process.

3.) Characterize challenges and barriers to effective practice across Maryland AIPs

Program staff perspectives on the challenges they face in conducting this work. All providers sampled for this research indicated facing some challenges and barriers in conducting AIP work. The most frequently reported challenge facing AIP providers involved funding limitations (n=32, 84%). Most AIP providers reported that they rely on AIP clients' payments as a primary funding source with little support from state monies or grant funding. At the same time, AIP clients often have financial problems and may have difficulties paying AIP fees. Providers from multi-service agencies were also quick to clarify that while grant monies often support their victim service programs, such funding cannot be used for their AIP work. Taken together, funding limitations create a substantial challenge to AIPs in that they must strike a balance between covering their operating costs and providing access to all Marylanders that need

AIP services – many of whom are court-ordered to their programs. Funding limitations also complicate AIPs ability to provide financial assistance to participants (e.g., through a sliding scale). One provider summed up the quagmire of funding limitations like this: *"as a non-profit agency, there is not a lot of money being brought into the program to pay for resources or staff, but clients with various socioeconomic backgrounds are also being court-ordered to come to treatment when they cannot necessarily afford the program fees."*

Funding challenges are closely related to staffing challenges, which is considered a barrier by 21 AIP providers (55%). Limitations in funding prevent most AIPs from employing full-time staff. Several providers indicated that all (or almost all) of their staff work part-time and that some staff members are expected to "wear several hats" in order to maintain the AIP's operations. Given the part time status of most AIP staff positions, recruiting and retaining qualified group facilitators is also a primary challenge. Of specific note is the challenge of finding qualified, male facilitators/co-facilitators. As explained by one provider: *"The main thing I would like to have around staffing is a really good male facilitator…I do believe that if our guys were able to see that in group where you have a male and female facilitator and see how they interact with each other…I think that would be great*".

Funding limitations also impact the quality of materials and delivery modalities (e.g., such as a projectors or videos) available for group sessions. Several providers noted that the materials they do have (e.g., videos) are so outdated that clients are distracted from the actual material content.

Further, seven providers (18%) reported that their AIP lacked physical space to hold AIP group sessions. These space issues are primarily solved by depending on the facilitator's own contacts or the "good will" of other local non-profit agencies. For instance, one AIP program

facilitator who also works full time at a psychiatric rehabilitation agency uses space at the rehabilitation agency for the AIP group. This individual noted that the space does not have cameras or security, which poses a safety issue for the facilitator and clients. The provider also explained that if the rehabilitation agency was to withdraw its permission to hold the AIP group there, they would "be scrambling" to find another space. Another provider holds AIP groups in the lobby of local nonprofit in the community and reports that non-profit staff and visitors regularly pass through the space and disrupt group sessions. A third provider explained that their program holds groups in multiple different MD counties, so facilitators often need to travel to local non-profits in various counties to conduct groups.

Elucidate the working relationships of Maryland AIP's with local legal systems, referral sources, and service providers.

Positive Relationships with the Courts. Sixteen providers (42%) identified an overall positive relationship with the court system. These positive relationships include open communication – most often by email and/or phone – with court personnel (e.g., state's attorneys, court clerks, and/or judicial secretaries, etc.). One provider described her communication with the judges in her jurisdiction as "amazing," indicating that calling/emailing is frequent and that the AIP holds weekly meetings with the state's attorney, district court judges, and circuit judges. Another provider described his relationship with the local judge as *"part of the wonderful aspect of the experience for me, I feel like I have friends or colleagues who I collaborate with to really help people"*. Another provider explained a strong partnership with the courts as the result of an extensive effort to promote AIP within her jurisdiction and maintain weekly contact with the court.

In addition to open-communication, some AIP providers reported a consistent feedback loop between the court and the AIP program regarding AIP client referrals to the AIP program

and AIP client progress and/or completion/termination. For example, in one jurisdiction, the court uses a referral form for offenders ordered to the local AIP, which details the offender's information, the case number, and the date, and is signed by the judge; it also explicitly indicates that the offender must call the AIP within two days (see Appendix C). Further, the form is "multi-layered" such that the offender, the AIP, and probation receive a copy from the court, and the court retains a copy so all "stakeholders" are informed. The AIP receives the copy in the mail from the court, so they can anticipate all new referrals from this jurisdiction. They can also call their contact at the court if a new referral does not enroll or complete their intake within the set period of time. Probation/parole can also use the information to check in on AIP client compliance. Further, there is a place for the AIP to sign regarding the offender's date of intake and their AIP completion/termination that is submitted back to the court. Using this model, the AIP receives verification of new referrals from the court and the court receives verification of new AIP enrollments and completions/terminations from the AIP and probation/parole can easily be kept informed.

Relationships with the Courts that could be Improved. Twenty-two (58%) AIP providers reported that some aspect(s) of their relationship with the courts, most often regarding communication or referrals, could use improvement. Several AIP providers reported that they receive little to no information from the courts on offenders who have been ordered to enroll in their program. One provider noted, *"it can be a little frustrating, because sometimes we have referral sources call and they want a status update on someone and I have no idea who that person is. We haven't heard from them."* Likewise, another AIP provider reported, *"with the courts, where they tell the guys to go to [our AIP], they don't tell us that they told to the guy to go to [our AIP], so they never go to [our AIP], there's no oversight really, there's no*

accountability. Maybe in two years when they're supposed to have the program done and the courts come knocking and they find out he hasn't done anything, then he just goes to jail and that doesn't really help anybody."

AIP providers also reported that communication with judges specifically could be improved. From the perspective of AIP staff, AIP-judicial miscommunication stemmed from one of two main issues: (1) judges viewed AIPs as a panacea and referred offenders who committed animal abuse, sexual offenses, and domestic violence against non-intimate partners to their programs or (2) judges rarely referred offenders to their program. To combat such problems, several AIP providers indicated that they try to consistently "remind" judges about the purpose and availability of their AIP through meetings and phone calls and attempt to increase their visibility in the community by being present at all relevant events and meetings. Issues obtaining judicial referrals seemed especially problematic for new AIP programs. One provider reported, "*With the court system, we have marketed… but I think that understandably, oftentimes the court is still referring to the same programs they always have been… out of comfort or knowing that program… that will just take time."*

Positive Relationships with Parole and Probation. Half of providers identified positive aspects of their relationship with parole and probation; again, citing open communication as a key, positive factor. Providers described parole and probation, particularly the Domestic Violence Specialist Agents, as responsive to their phone calls and emails. Many providers reported that they have standing meetings (e.g., quarterly) with agents and that they can call the probation agent between meetings when they need information on an AIP client. For example, one AIP provider noted, *"The probation officer can always call us and say 'hey I'm a little bit worried maybe you should talk to a client about this' and we can always call them and say, 'I'm*

worried about the client I haven't seen her in a while, do you know what's going on or can you ask them to call us back?'" AIP providers also reported feeling that clients who are on supervised probation are incentivized to perform better in their AIP compared to those who are not supervised by a probation/parole agent.

An important element of successful collaboration between AIP providers and parole and probation includes monthly status reports by AIP providers (to parole and probation). Status reports include a client's attendance, fee balance, and performance in group. The status updates also provide AIP provider the opportunity to communicate any concerns regarding a client's progress to parole and probation officers.

Relationships with Probation/Parole that could be improved. At the same time, 50% of AIP providers revealed that their relationship with parole and probation needs improvement, again, particularly around amount and quality of communication. For example, AIP providers are often reliant on probation and parole to inform them if an AIP client is arrested, and without such communication, AIP staff often waste time repeatedly contacting the AIP client or are simply left wondering what happened to the client. In addition, in jurisdictions where probation and parole serve as a referral source and communication is poor, previously described problems in tracking referred clients occur. One AIP provider explained, *"we'll get a call from parole and probation…months later [after the offender was referred to the AIP]. [The probation agent indicates] 'I'm getting ready to violate this guy' and I'm like 'what guy?'"*

Relationships with Other Referral Sources. Depending on geographic location, some AIP agencies receive referrals from other state agencies, such as Department of Social Services (DSS) or the county's Family Center. One AIP provider explained that her AIP's location on Maryland's border also results in court referrals from outside of Maryland. Overall, AIPs

reported positive relationships with these outside referral sources. For instance, one provider explained that staff from the county's Family Center refers clients to their AIP program, presents guest lectures at AIP group sessions, and maintains contact with the agency. In fact, according to the AIP provider, this particular referral source has been "an integral part of our trying to connect with agencies for years at this point." Likewise, for AIPs that receive referrals from DSS, providers report that clients are generally matched to the AIP location that is most geographically appropriate for clients. Another positive aspect of DSS reported by providers includes the provision of a full packet of information on the client (police reports, intake, court documents) as well as a strong feedback loop regarding referrals, coordinated monthly reports, and inquiries on a clients' compliance. At the same time, some relationships with outside referral agencies do suffer some strain because of the large number of agency staff, which makes it difficult to develop a consistent relationship.

Referrals for Substance Abuse and Mental Health. All providers indicated that referrals to external agencies for clients who need treatment for substance abuse or mental health problems are accessible when necessary. Eleven providers (30%) say that treatment for substance abuse and/or mental health must be completed before the client can engage in AIP, 46% indicated that clients may complete treatment for substance abuse and/or mental health concurrently with AIP, and 24% did not specify the timing of treatment for co-occurring issues. Further, 22% of AIP providers indicated that the majority of their clients who needed treatment for a co-occurring substance abuse/mental health issue have already been referred to treatment by the courts or their probation agent prior to enrolling in AIP. Determinations regarding external referrals are most often made during the intake process. In addition, seven providers explained that at least partial treatment for co-occurring issues may be addressed at the AIP.

Identify ways in which the Maryland AIP Guidelines can facilitate and promote best practices

The majority of AIP providers reported familiarity with the Maryland AIP Guidelines; however, eight (21%) of the direct service providers interviewed (i.e., AIP group facilitators) indicated that they were not familiar with the guidelines, and thus, were not asked questions about the guidelines.

Twenty-eight (88%) of the providers familiar with the guidelines agreed that there were aspects of the guidelines that were helpful to their AIP practice. Overall, most providers indicated that having the guidelines provides necessary structure for Maryland AIPs. Regarding individual elements of the guidelines, the most cited "helpful" aspect of the guidelines was the requirement to complete victim outreach. One provider explained that victim notification keeps people feeling safe. While another provider indicated that: *"… from the get go we are in contact with the victim, not in the sense that she is spying on the participant, but more 'does she know that he's in the process' and 'does she know that we as an agency offer services for her?' So I think that is huge."*

At the same time, seven (22%) providers familiar with the guidelines reported difficulties regarding victim contacts (e.g., obtaining contact information for the victim, actually reaching the victim, or having the time to routinely follow up with the victim). One repetitive challenge was associated with AIPs primary source of victim contact information: the AIP client. Many times the victim has a protective order against the AIP client and the AIP client is hesitant to provide victim contact information, even to AIP staff, given protective order restrictions on "third party contact". Thus, for some AIP programs victim contacts often do not occur. However, several AIP providers reported alternative models for obtaining victim contact information that

yield greater success. In one jurisdiction, the AIP utilizes the victim/witness service provider to obtain victim contact information, and in some cases, actual victim outreach. Similarly, another provider reported using Maryland case search to assist them in identifying victims.

Further, providers noted that the staff credentialing and training requirements are helpful aspects of the guidelines. As one provider explained, *"It is important to know what this field is really about… it really is something that you want to know and understand (the problem of IPV) and what that means and how we can work in the community."* At the same time, many providers expressed dissatisfaction with the current training and certification process. Given that most MD AIPs are staffed primarily with part-time employees, sending staff offsite to training presents a substantial challenge (e.g., trainings are offered infrequently there is significant cost related to financially supporting multi-day training trips). One provider described that the AIP was not able to hold group because two facilitators had yet to attend the annual training. Another provider expressed frustration with training requirements because her AIP experiences high staff turnover. She explained that her *"has had three different AIP co-facilitators come and go in the last 3 years. So for us to hire someone and not have them even be able to assist in co-facilitating and group until they have attended trainings that happen once a year, three hours a day, three days in a row and it costs money and the hotel costs money… if you don't hire in the spring, say October, they can't facilitate a group until they've gone through the trainings in April and March"*.

Recommendations and Conclusions

1) Providers were quite consistent in conveying the importance of several key elements of AIP practice, including: a) the need for effective strategies to address participants' initial resistance (to reduce minimization and blaming and enhance accountability and change)

b) the importance of establishing a collaborative relationship with AIP participants to promote program goals, and c) the value of positive group interactions (including role modeling) to promote change. All of these insights are consistent with available research on AIP efficacy. However, there is also considerable variation in how Maryland AIPs approach these key areas of practice, highlighting: a) the need for further research on best practices for motivating participants to change, establishing collaborative relationships, and facilitating effective group interactions; and b) effective methods to disseminate these practices.

2) Providers conveyed many possible change targets for AIP work, and had divergent views on the value of structured program materials. Given that: a) behavior change efforts are typically enhanced through practice and application between counseling sessions, and b) some AIP providers expressed considerable enthusiasm about their use of structured program materials, important next steps to promote best practices may involve efforts to gather and/or create resource materials to promote structured program interventions that address the key change targets identified by AIP providers.
3) Providers differ substantially in their efforts to evaluate and address individual problems that may influence the effectiveness of AIP services. Key examples include substance use disorders, serious mental health concerns (e.g., psychotic and mood disorders), traumatic stress reactions, and life complications such as unemployment and housing instability. The available research indicates that such factors are often associated with increased risk for violence recidivism, and therefore movement toward best practice will require increased responsiveness to individual needs and risk profiles. These efforts may be facilitating by organizing resource materials and providing training to help AIPs assess

key individual problems and risk factors in an accurate and efficient fashion, and by developing and disseminating effective strategies to reduce violence risk linked to individual problems (e.g., substance abuse, mental health problems) that are not sufficiently addressed within standard AIP practice.

4) Providers indicated that there was substantial need for evaluation regarding the association between AIP completion and future recidivism. Providers noted that there was a lack of understanding regarding the impact of their program on behavioral change among their clients – beyond anecdotal evidence – especially over time.
5) The level of financial and infrastructure support for Maryland AIPs is woefully inadequate to promote full implementation of best practices. Resource limitations affect many key aspects of AIP practice, including Programs' ability to recruit, train, and retain AIP staff; their capacity to assist low-income AIP participants; and their ability to provide timely services following best practice models (e.g., maintaining manageable group sizes, offering accessible services in rural communities; addressing co-occurring problems with mental health and substance abuse, etc.). This situation reflects broader societal trends in which endemic public health problems associated with violence receive less attention and resources than acute epidemic public health problems (such as Zika, Ebola, etc.) that affect far fewer individuals and have much less overall negative influence on public welfare. AIP collaboratives such as the Governor's Family Violence Council certification workgroup and MAIC might explore relationships with Maryland legislator's to craft legislation to increase state funding for AIPs. Further, such collaboratives might consider developing a collective application for federal funding streams with program priorities regarding offender rehabilitation and recidivism

reduction such as the Edward J. Byrne Memorial Bureau of Justice Assistance Grant Program and/or the Justice Reinvestment Initiative Grant funds.

6) AIP coordination with referring sources is highly variable and is an important area for program practice enhancement. Our analysis uncovered some exemplary models to support effective communication and careful monitoring of referrals and compliance. Individual AIPs should consider the viability of such models for their program/jurisdiction and consider adopting such innovations or modifying innovations to improve their program practice. Improving practice in this area is likely to reduce the number of high-risk cases that avoid AIP services and the potential legal consequences of noncompliance. Research has indicated that greater coordination of the community response to IPV is likely to reduce violence recidivism.
7) Limited training and credentialing options serve as a significant barrier to AIP work. AIP staff at programs that are geographically isolated face increased challenges in that they must travel to multi-day trainings, which requires their absence from work in addition to monetary travel support. Further, training is offered infrequently, which becomes problematic when staff are hired mid-year and must wait months until they can take the necessary training. The AIP Certification Workgroup is encouraged to develop more options for training delivery and increase the frequency in which training is offered. Training modalities may include delivering training in the form of streaming online presentations and/or webinars. Utilizing such technology will reduce travel time and cost for trainees and trainers and supports increased frequency of trainings.

References

Babcock, J., Cannon, C., Lauve-Moon, K., Buttell, F., Cantos, A., Hamel, J., et al. (in press). Domestic violence perpetrator programs: A proposal for evidence-based standards in the United States. *Partner Abuse*.

Berg, (2004).

Boal, A.L., & Mankowski, E.S. (2014). The impact of legislative standards on batterer intervention program practices and characteristics. *American Journal of Community Psychology, 53* (1), 218-230.

Bonta, J., & Andrews, D.A. (2007). *Risk-need-responsivity model for offender assessment and rehabilitation (Corrections Research User Report No. 2007-06).* Ottawa, ON: Public Safety Canada.

Felson, R.B., & Pare P. (2005). The reporting of domestic violence and sexual assault by nonstrangers to the police. *Journal of Marriage and Family, 67* (3), 597-610.

Gondolf, E.W. (1999). Characteristics of court-mandated batterers in four cities: Diversity and dichotomies. *Violence Against Women, 5* (11), 1277-1293.

Governor's Family Violence Council [GFVC]. (2015). 2015 Certified Abuse Intervention Programs. Available from http://goccp.maryland.gov/victims/family-violence-council/abuse-intervention/

Maryland Family Violence Council [MFVC]. (1996). Stop the violence: A call to action. Recommendations and action plan. Available from the Maryland Attorney General's and Lt. Governor's Family Violence Council. 200 St. Paul Place 16th Floor, Baltimore, MD 21202.

Maryland Network Against Domestic Violence [MNADV]. (2016). 2016 Memorial Fact Sheet.

Retrieved from http://mnadv.org/about-domestic-violence/deaths-in-maryland/

Maryland Uniform Crime Reporting (UCR) Program. (2015). 2014 Uniform Crime Report. Retrieved from http://mdsp.maryland.gov/Document%20Downloads/2014_MD_Crime_UCR.pdf

Maiuro, R.D., & Eberle J.A. (2008). State standards for domestic violence perpetrator treatment: Current status, trends, and recommendations. *Violence and Victims, 23* (2), 133-155.

Murphy, C.M. (2002). Toward empirically based standards for abuser intervention: The Maryland model. *Journal of Aggression, Maltreatment & Trauma, 5* (2), 249-264.

Pence, E., & Paymar M. (1993). *Education groups for men who batter: The Duluth model.* New York, NY. Springer Publishing Company, Inc.

Potter-Efron, R. (2001). *Stop the Anger Now.* Oakland, CA: New Harbinger.

Price, B.J., & Rosenbaum A. (2009). Batterer intervention programs: A report from the field. *Violence and Victims, 24* (6), 757-770.

Wexler, D.B. (2013). *The STOP Domestic Violence Program*. New York: W.W. Norton.

Appendix A: Interview Script

Introduction: This interview focuses on your perspectives on abuser intervention work, including your program philosophy, your view of the change process, practices and policies that you feel are most helpful in achieving program goals, and how an ideal abuser intervention program might be organized. In addition, the interview also focuses on how your program is organized, your specific program activities, the relationships that you have with referral and monitoring sources such as the court or probation department, and the challenges that you face in doing abuser intervention work. We are also interested in your ideas about the Maryland Operating Guidelines for Abuser Intervention Programs.

This interview will be audio-recorded and then transcribed by a trained research assistant. Once the interview is transcribed, this audio file will be destroyed. Transcribed interview responses will be de-identified and kept confidential. Neither you, nor your abuser intervention program, will be directly associated with your interview responses.

Interview Questions:

1. Can you please describe the philosophy or intervention approach used by your AIP?

2. Can you please explain the change process that participants go through to end violence and abuse?

3. In your opinion, what are the key change targets for AIP work?

4. What are the most important skills or concepts for clients to gain or learn at the AIP?

5. How does your program address these change targets and goals – what strategies or practices do you use to achieve the program goals?

6. Do you have any strategies in place to determine if participants are meeting the goals for change?
    a. (if so, what are those strategies, do they involve outcome measures)?

7. What do you feel are the most successful elements or strategies in your program?

8. In your opinion, what would an ideal AIP look like (what features would it have)?

9. Are there any practical barriers that preclude a more ideal implementation for your program?

10. What challenges does your program face?*(e.g., staffing, funding limitations, difficult population)?*

11. Does your AIP use information from the intake assessments to determine AIP clients' treatment content or referrals to external agencies? (e.g., information regarding substance abuse, prior trauma/victimization, mental health, etc.).

12. How would you describe the relationship between your program and the courts? (or other referral and monitoring sources)?
    a. What is your program doing that works well in accessing referrals and communicating with referral and monitoring sources?
    b. What challenges does your program face in accessing referrals and communicating with referral and monitoring sources?

13. Are you familiar with the Maryland AIP guidelines? If so, …

14. What aspects of the guidelines do you see as helpful or constructive?

15. What aspects of the guidelines present challenges for your program? (and what are those challenges?)

16. Are there any aspects of the guidelines AIPs would you like to see changed?

17. Are there any other aspects of your program philosophy, goals, program practices, or challenges that we missed in our interview questions?

Appendix 2: Case File Checklist

DOCUMENT	CURRENT CASE FILE 1	CURRENT CASE FILE 2	COMPLETED CASE FILE 1	COMPLETED CASE FILE 2	COMPLETED CASE FILE 3
Intake Form					
Waiver of Confidentiality Form					
Victim Notification Letter					
Victim Phone Checklist					
Group Contract					
Duty to Warn					
Monthly Status Report					
Program Completion Notice					
EXTRA NOTES					
Docs not scanned in case files					

OVERALL IMPRESSIONS OF CASE FILES:

Appendix C: Example Referral Source-AIP Verification Form

[redacted]

Domestic Violence Counseling Program

[redacted] [redacted]

COURT: _____

CASE NO.: _____ **DATE:** _____

NAME: _____

ADDRESS: _____

CITY/TOWN: _____ **STATE:** _____ **ZIP CODE:** _____

PHONE NO.: _____

JUDGE'S NAME: _____

SIGNATURE: _____

THE ABOVE NAMED INDIVIDUAL HAS BEEN REFERRED TO [redacted] TO ATTEND AND COMPLETE THE 26-WEEK ABUSER INTERVENTION PROGRAM.

NOTE: THE INDIVIDUAL IS TO CALL FOR INTAKE WITHIN TWO DAYS OF THE ABOVE DATE.

ENROLLMENT VERIFICATION

THE ABOVE NAMED INDIVIDUAL HAS ENROLLED IN THE 26-WEEK [redacted] PROGRAM.

_____ _____ _____

Provider's Signature Date Client's Signature

COMPLETION STATUS

The above named individual _____has _____ has not complied with the program requirements.

_____ _____

Provider's Signature Date

WHITE COPY: COURT OR PROBATION AGENT
YELLOW COPY: DEFENDANT
PINK COPY: [redacted]
GOLDENROD COPY: COURT (AT TIME OF COMPLETION/TERMINATION)