STANDARDS FOR BATTERER INTERVENTION PROGRAMS IN CANADA: A HISTORY AND REVIEW

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ABSTRACT

This article reports on the growing trend of setting standards for intervention with batterers. All existing Canadian standards for batterer intervention programs (BIPs) are examined, including a discussion on how they came into effect and any controversy associated with their development. A brief background of the battering intervention field and the growth of BIP standards in North America is provided, followed by a description of the types and content of Canadian standards. Compliance with standards were mandatory in two regions and voluntary in three others. Two more regions had standards in a draft stage of development. Elements of standards typically included directives on: general program goals; the protocol and procedures programs should follow, including counselling format; and program staff ethics and qualifications. The article concludes with a discussion of the findings and suggestions for improving standards.

Approximately two decades after psychosocial counselling for domestic violence perpetrators had been introduced as part of a broader strategy to counter abuse within intimate relationships, standards for batterer intervention programs (BIPs) began to be developed in the U.S. at the end of the 1980s and somewhat later in Canada (Austin & Dankwort, 1999; Battered Women's Justice Project, 1995). Though the intent was to bring more treatment uniformity based on safety concerns for abuse victims, the call for standardizing this intervention also came under mounting criticism (Goldman, 1991; Gondolf, 1992; Gefner, 1995a, 1995b; Gondolf, 1995; Hessmiller-Trego, 1991; Moore, Greenfield, Wilson, & Kok, 1997; Bennett, 1998) which embodied many long-standing and ongoing controversies in the field (viz., Davis, 1987; DeKeseredy & MacLeod, 1997; Francis & Tsang, 1997; Gelles & Loseke, 1993; Walker, 1990).

The present article reports on the first comprehensive review of Canadian BIP standards. Using a national directory (Health Canada, 1997) as an initial source, domestic violence resources were identified and contacted by telephone in each province or territory to ascertain if BIP standards existed or were in the process of being developed. In addition, telephone respondents were also asked (a) to discuss how standards were developed (or were in the process of being developed) in their respective region, and (b) if they knew of any controversy associated with BIP standards in their respective region. Telephone contacts were made in all regions, and seven documents were subsequently obtained and analyzed for their content.[1]

Given the growing trend to regulate interventions with batterers, this review provides timely and vital information to practitioner-providers, law-enforcement

personnel, scholars, victim advocates, and policy-makers in Canada. In order to fully appreciate the development and significance of batterer intervention standards, we begin with a brief background of the battering intervention field in North America and then discuss how this history shaped standards in both the U.S. and Canada. We next provide a summary of the prevalence and content of Canadian standards, followed by an analysis of these findings and our concluding recommendations.

OVERVIEW OF BATTERER INTERVENTION IN NORTH AMERICA

Following the establishment of victims' services and a commitment by police and the justice system to intervene in domestic violence cases which were once widely regarded as a private family matter, batterer intervention and prevention programs grew at an exponential rate to help meet the demand of managing apprehended perpetrators (Chalk & King, 1998; Health Canada, 1997; Jennings, 1987).

However, as these programs gained legitimacy, concerns and conflicting views on safe and appropriate intervention also surfaced. Divergent approaches to remedying spouse or wife abuse resulted from different conceptualizations of the problem illustrated in fundamental and enduring questions about the nature of battering, batterers, and preferred intervention strategies (Adams, 1988; Bograd, 1984; Dankwort, 1988a, 1988c; Moore, Greenfield, Wilson, & Kok, 1997). For example, battered women's advocates saw domestic violence as being chiefly a manifestation of patriarchy which required intervention to be focused on men's socially-reinforced, intentional abuse of power and control over their partners (Dobash & Dobash, 1992; Hart, 1988; Lacombe, 1990; Pagelow, 1984). Prosecution for woman abuse was demanded, even while state involvement through law enforcement was perceived by some as a questionable strategy (Rigakos, 1998; Flynn & Crawford, 1998). Though the police and the courts might provide women with protection, these were also seen as some of the most enduring institutions of patriarchy—plagued by racism, a legacy of oppression, and often disempowering for victims or survivors (Currie & MacLean, 1992; DeKeseredy & Macleod, 1997; Snider, 1998).

Others viewed battering from a more traditional therapeutic perspective which, while not excluding the social context entirely, foregrounded a wide range of interventions addressing individual or interpersonal pathology and dysfunctions. Remedies included psychiatry and psychotherapy (Faulk, 1977; Shainess, 1977; Saunders, 1984; Snell, Rosenwald, & Robey, 1964); anger-management, stress-awareness, relaxation, and social skills training (Currie, 1983; Deschner, 1984; Dutton, 1984; Guévremont, 1986; Maiuro, Cahn, & Vitaliano, 1986; Phillipe, 1986; Purdy & Nickle, 1981); and couples or family counselling (Coleman, 1980; Cook & Frantz-Cook, 1984; Geller, 1982; Magill & Werk, 1985). Critics, advocating interventions highlighting patriarchal inequity, feared such clinical responses would further compromise victim safety, merely stabilize abusive relationship patterns, minimize perpetrator accountability, and largely ignore societal supports undergirding the violence (Adams, 1988; Avis, 1992; Carrier & Michaud, 1982; Dobash & Dobash, 1992; Gondolf & Russell, 1986; Maynard, 1985; Hansen, 1993; Sedlak, 1988; Stark & Flitcraft, 1988; Storrie & Poon, 1991; Yllö, 1993). Compounding such apprehensions was the legacy of battered women historically encountering

skepticism, disbelief, and victim-blaming when they turned to mental health professionals, which did little to reassure them and their advocates (especially in the face of life-and-death matters) that a woman's well-being could safely be entrusted to the care of such experts (Dobash & Dobash, 1979; Holten, 1990; King, 1981; Okun, 1986; Schechter, 1982).

Concern and controversy over increasing psychosocial provisions for batterers soon surfaced in several Canadian provinces and, on occasion, became the heated topic of the electronic and print media (Dankwort, 1988c; Walker, 1990; Francis & Tsang, 1997). Perhaps the most telling accounts comprised the testimony of directors for Ontario and Quebec associations of transition houses and rape crisis centres before a House of Commons Sub-Committee on the Status of Women (Canada, House of Commons, 1991). They revealed grave misgivings about how BIPs may further obscure underlying socio-political causes for the violence, since such intervention was now offered by hundreds of programs in many settings, ranging from autonomous men's organizations and private mental health providers to family service agencies, hospitals, and government-funded mental health centres. "Treatment" subsequent to police intervention, for example, might merely teach men to better control spouses without actually hitting them, thereby enabling batterers to both avoid criminal sanction *and* maintain the advantageous positions derived from unequal gender-based power relations. Thus they argued that, even though the involvement of government had helped in taking the problem out from behind closed doors and publicizing the social dimensions of battering, ensuing referrals to the therapeutic community risked a redefinition of the problem as individual pathology (Dankwort, 1994; Holmes & Lundy, 1990; Storrie & Poon, 1991; Walker, 1990).

While differing views and varying strategies characterized the domestic violence field, a more thorough reading shows interests of stakeholders and interventions to have been both convergent and divergent, at times contradictory, overlapping, and conflicting. For example, using the police, the courts, probation, and parole services generally did coincide with demands for greater safety and protection demanded by battered women advocates. However, as Snider (1998) and others have written, the limits of a legal response to battering (not to mention inconsistent findings from research examining recidivism in terms of arrest, counselling, and "no-treatment") became increasingly evident over time: imprisonment (when it did occur) only provided temporary safety for victims; victims often declined to report assault or to testify in court; and pro-charge policies were applied unevenly. For their part, mental health professionals came to endorse the view that assault in the privacy of the home constituted criminal behavior and many increasingly began to work in tandem with domestic violence community projects (Pence, 1989). However, their practice was also grounded within a tradition of humanistic (and family) values marked by compassion or caring in *all* interventions with clients—victim *and* offender. Programs for batterers thus came up against the tensions inherent in a mix of both social control and offender rehabilitation agendas—the clinical side of family violence and the legal side of the problem (Bolton & Bolton, 1987). That, in turn, was expressed in conflict surfacing between professional and paraprofessional, researcher and practitioner, activist and service provider (Caesar & Hamberger, 1989).

To be sure, these differing views and tensions have marked the development of BIPs in terms of program protocol, program policies, the use of varying

intervention formats, and the more basic question of whether they should even be offered and funded (Adams, 1988; Bograd, 1984; Dankwort, 1988a, 1988c, 1991, 1994; Lacombe, 1990).

Even though research in the battering field has grown in quantity and sophistication over the past two decades, the key question about the effectiveness of interventions remains unanswered. Reasons for this uncertain verdict have been discussed at length elsewhere (Chalk & King, 1998; Dankwort, 1988c; Edleson & Eisikovitz, 1996; Edleson & Tolman, 1993; Gondolf, 1987a, 1987b, 1997a), and are beyond the scope of this article. Suffice it to say that studies have extensively examined the psychological profiles of batterers, varying counselling formats (group or couples counselling), program length (short or long duration), treatment success based on recidivism rates, and, more recently, program mode (e.g., self-help, process-psychodynamic, educational), yet furnishing convincing evidence about "what works" remains elusive. Important methodology limitations which inhere in the prevailing positivist approach of these studies are central in explaining an inability to resolve this uncertainty. They include: (a) bias in assigning subjects; (b) difficulty in isolating the variable(s) being tested from other factors possibly accounting for change; (c) high sample attrition rates; (d) limited validity of data sources (e.g., crime reports, self reports); (e) inadequate instruments measuring change; and, (f) lack of definitional consistency about what constitutes criteria for "success."

There does appear to be some consensus amongst researchers who have systematically reviewed U.S. studies about BIP effectiveness that men completing treatment do abstain from violence for at least a period of time subsequent to "treatment;" but, significantly, the agent or variable(s) responsible for that change remain(s) uncertain (Edleson & Eisikovitz, 1996; Gondolf, 1997b; Tolman & Edleson, 1995). Similar dubiety marked a review of program evaluations by the Canadian Department of Justice, which wrote that "some modest success of group treatment" after six months to one year can be discerned with "improvements" for about half of program completers when compared to no-treatment and/or arrest only recidivism rates (Correctional Service Canada, 1989). Yet, here again, the cause of change is viewed as questionable, moving some to call now for innovative research designs, broadening the conceptual realm of such investigation to assess the social impact of a coordinated, multi-resource intervention project (of which a BIP is only one part), and to probe, through qualitative methods, victims' accounts of their perceptions of BIP services, their partners, and their sense of violence, fear, or safety (Dankwort, 1998; Gondolf, 1997b; Edleson & Eisikovitz, 1996; Austin & Dankwort, 1999).

OVERVIEW OF BIP STANDARDS IN THE U.S.

Against this backdrop, one can readily appreciate how the growth of batterer programs, with their myriad approaches and their potential to either help or further compromise domestic-violence victims, provided strong incentives for finding ways to protect the public in general, and battered women in particular. Creating standards which would delineate psychosocial intervention thus appeared to be an obvious and direct way of responding to this imperative (Schonberg, 1995).

Standards for batterer programs were first created in the United States, where

the first group treatment or accountability[2] groups for wife abusers had been developed. Beginning in the mid-eighties, committees comprised of battered women's advocates, counsellors of batterer programs, justice-system personnel, educators, and mental health professionals were formed to develop such standards. As of February 1997, 24 states had developed standards, 7 had standards in draft form, and 13 states plus the District of Columbia were in the process of developing them (Austin & Dankwort, 1999).

Standards in the U.S. were relatively similar, with one state's guidelines often serving as a model for others developing their own. In general, BIP standards throughout the U.S.—whether compliance was deemed mandatory or voluntary for the designated service providers—shared two fundamental principles. Both victim safety and offender and BIP accountability constituted common references for directives and suggested protocol. The strong influence of the battered women's movement was evident in numerous ways, including how abuse was defined as a coercive pattern of control, and how patriarchy was foregrounded as causing and/or maintaining men's violence against women (viz., Colorado, 1989; Massachusetts, 1991). Most standards elaborated on the limits of client confidentiality and the need for partner contacts. Batterer programs were instructed to work in close collaboration with victims' services, the justice system, and other collateral mental health services, while undertaking community education on domestic violence and providing group sessions for batterers.

The standards declared a preference for "psycho-educational," "pro-feminist," or "cognitive-behavioural" models when working with batterers for a suggested duration that averaged between 24 to 26 weekly sessions. The indicated intervention format was the use of group sessions, while both one-on-one and couples counselling were identified as inappropriate primary intervention. Most standards also specified discharge and program completion requirements for participants so as to help bolster accountability to victims and the larger community.

Such prescriptions and proscriptions rekindled controversies which have marked the field of domestic violence since it first became the topic of research and discussion in the literature. Some clinicians and scholars regard a number of requirements in BIP standards (such as program orientation and counselling formats) to be an infringement on the right to practice according to one's professional training (Goldman, 1991; Geffner, 1995a). In rebuttal, both inadequate interventions by therapists and the importance of a precise curriculum with batterers which targets abusive behaviours are offered as reasonable justifications for regulating mental health professionals and their practice. Gondolf (1992), observing that standards also have been created to regulate intervention in the substance and sexual abuse fields, identifies studies which have shown how professionals from varying backgrounds have unwittingly contributed to the neglect of domestic violence in clinical assessments and treatment. Adams (1995) provides anecdotal evidence to support the view that generic mental health counselling has shown itself to be ineffective with batterers, because they are often not confronted with their behaviours and thus fail to take responsibility for their abuse. Neglecting that sense of resonsibility means missing the crucial first step towards renouncing one's violence, because, it is believed, where responsibility is unclear, the risk of re-victimization rises. Delineating a practice which is focused on the abusive behaviour made possible only through clear allocation of perpetrator responsibility is congruent with

empirical research in other fields suggesting effective offender interventions (Hanson & Whitman, 1995).

The critique of standards is additionally made through claims that, because no "scientific" evidence exists to support a given approach, format, or curriculum length, standards should neither prescribe nor proscribe in these areas (Rosenbaum & Stewart, 1994). Some also see the possibility of evaluating varying programs (for example, programs utilizing couples versus group sessions) to be hampered seriously by virtue of the same proscriptions limiting practice choices (Rosenbaum & Stewart, 1994; Geffner, 1995a). Those who agree with proscriptions in many standards regarding counselling format (e.g., couples counselling), structure (e.g., unmonitored self-help group), or a particular mode (e.g., ventilation model) point to the decades of practical experience accumulated from the batterer field which should not be regarded with less credibility (i.e., as "unscientific") than positivist-based research. Rather, they argue that field experience should serve as reliable information to guide one's practice—until, at least, it can be demonstrated that standardized interventions are misplaced or unfounded (Bennett, 1998; Gondolf, 1995).

Finally, some mental health clinicians are objecting strongly to the lack of professional credentialing requirements for BIP staff, arguing that batterers are not a homogeneous population and that some have psychological impairments which require the help only trained professionals can give them (Rosenbaum & Stewart, 1994; Geffner, 1995a). The counter-argument here has refuted clinical expertise as a requisite to work with batterers because battering, rather than a psychological problem requiring clinical treatment, is held fundamentally to constitute a social problem stemming from patriarchy. From that perspective, changing belief systems comprised of male entitlement and privilege underpinning abusive behaviour must be the agenda, facilitated by those with specialized training in precisely that orbit (Gondolf, 1992; Platt, 1992; Hessmiller-Trego, 1991). In line with this understanding, relationship or communication problems and personal growth issues may well have to be addressed in a conflicted marriage which is abusive, but the violent behaviour and safety issues must be prioritized and dealt with first. The rest can follow, if both partners are still willing and interested. Further, the point is made that, since standards direct BIPs to screen for mental disorders and substance abuse problems, recognition is in fact given that not all batterers are alike and that they may require individualized treatment (Bennett & Piet, 1999).

HISTORY OF CANADIAN BIP STANDARDS

Our review of documents and telephone interviews disclosed that the development of standards[3] in Canada emerged towards the end of the same decade as in the U.S., generally through initiatives jointly taken by provincial government ministries and administrators of batterer programs. In some cases, an interest in creating standards was expressed by additional stakeholders such as provincial associations of transition houses for battered women, but this influence appears to have been less pronounced than in the U.S. Evidence for this conclusion comes from a 1989 survey which surprisingly disclosed that these associations, for the most part, hardly knew what BIPs existed in their respective regions (Canadian Council on Social Development, 1989). Nevertheless, the standards themselves

usually were developed through designated committees which had mixed representation from government departments, BIP programs, women's groups, the justice system, and mental health services. Sometimes, however, as was the case in British Columbia, individuals with support through government-funded contracts (rather than committees) took on the major role in creating standards (Bell, Browning, & Hamilton, 1992).

It is worth noting that Canadian initiatives in working with domestic-violence perpetrators evolved in a somewhat different historical context than did those in the U.S. Since the development of batterer intervention in Canada occurred later than in the U.S. and had considerable input from mental health professionals (Browning, 1984), the strong pro-feminist grassroots, which characterized the essence of the first American BIPs in the 1970s, were eclipsed by a culture of professionalization as well as institutional and bureaucratic protocol that increasingly marked changes in the domestic violence field in both countries over the next decade (Adams, 1988; Beaudry, 1984; Davis, 1987; Schechter, 1982; Walker, 1990; Francis & Tsang, 1997). Seen in this light, it can be argued that developing standards in British Columbia, Ontario, and Quebec actually helped to establish and legitimize batterer programs as a needed and vital service towards eliminating domestic abuse in a climate of scepticism and controversy over the wisdom of investing in resources for batterer rehabilitation (Dankwort, 1988b; Dufresne, 1992; Francis & Tsang, 1997; Lacombe, 1990). Aside from the issue of who precisely moved the creation of BIP standards, the strong feminist influence in domestic-violence interventions in the U.S. imbued the text of Canadian standards (Francis & Tsang, 1997).

STATUS OF CANADIAN BIP STANDARDS

Table 1 provides an overview of the prevalence and type of batterer intervention regulation for Canada, indicating who develops and oversees standards. As of October 1997, three provinces had standards in place and two provinces and one territory had draft versions of standards. The Correctional Service of Canada (CSC) additionally produced a set of guiding principles in 1994 for offenders coming under its jurisdiction and receiving services through CSC rehabilitation programs.

When analyzed for their content, standards can be classified by two different types: either mandatory (requiring BIPs to comply with them) or voluntary (only serving as guidelines recommending intervention).

Four sets of Canadian standards (British Columbia, Ontario,[4] Quebec, and Saskatchewan) identified the particular service providers and clients for whom they were designated. These would be programs which received government funding and clients usually court-mandated to treatment. Adherence to standards in British Columbia (BC) and Ontario (ON) was only required for batterer programs that contracted with the respective provincial government department for funding—generally a service designated for clients referred by the courts. Hence, all other batterer programs had the option of following the standards or of ignoring them. While the guiding principles produced by (CSC) were intended for programs operating within a correctional setting, CSC also stated they are only intended to be flexible parameters. Unlike in the U.S., there existed no legislation in Canada which would oblige all batterer intervention programs in a given jurisdiction to abide by BIP standards. Because Saskatchewan (SK), Nova Scotia (NS), and the

Yukon Terrirtories (YK) only had drafts of standards, the matter of their compliance for BIPs had not yet been established at the time our interviews were conducted.

Quebec's (QC) voluntary guidelines for BIPs are seldom referenced and, as we note below, are not being considered even as a template for making proposed changes to batterer interventions, because they are not perceived by at least one of the province's associations of transition houses to have equivalent force when com-

TABLE 1

Status of Standards for Canadian Batterer Intervention Programs

Province/Territory	Status of Standards	Agency
British Columbia (BC)	Mandatory for programs receiving government funding (Some monitoring through audits by Government contractor)	BC Institute on Family Violence in collaboration with BC Ministry of the Attorney General, Corrections Branch; community consultations
Corrections Service Canada (CSC)	Recommended guidelines for all programs within Corrections Canada	Family Violence Unit, CSC in collaboration with CSC's Research and Statistics Branch
Nova Scotia (NS)	Draft version	Project New Start of Veith House in collaboration with NS Department of Justice
Ontario (ON)	Mandatory for programs contracting with Ontario Ministry of the Solicitor General and Ontario Correctional Services (Monitored through audits by Government contractor)	Ontario Ministry of Community and Social Services; Ontario Ministry of Correctional Services; Ontario Women's Directorate; community consultation
Quebec (QC)	Voluntary	Government of Quebec, Ministère de la Santé et des Services sociaux in consultation with domestic violence task force and community advisory committee
Saskatchewan (SK)	Draft version	Initiative of province's batterers' programs, Department of Health (Mental Health Services), and Provincial Association of Transition Houses
Yukon (YK)	Draft version	Initiative of Family Violence Prevention Unit's Assaultive Husbands Program

pared with existing QC inter-ministerial domestic-violence policy. Hence, the impact of that province's standards in the domestic-violence field appeared to be only marginal.

CONTENT OF CANADIAN BIP STANDARDS

The content of Canadian BIP standards could be organized by similar themes into ten broad categories and subcategories. Table 2 presents a synopsis of the content of each category by region. In general, Canadian standards resemble their American counterparts, addressing the substantive areas of batterer intervention which have, over two decades, come to be identified as especially relevant. Just over half of the standards gave a brief background account of their development and the purpose for their existence. Most standards discussed: program philosophy and how battering and batterers are conceptualized; the mode, format, and duration of intervention that programs should follow; the content of program curricula and the practice techniques which are recommended; a wide range of protocol governing strategies for outreach, collaboration with collateral resources, partner safety, intake, assessment, client contracting, referral, and terminating services; staff ethics and staff qualifications; program accountability; and evaluation issues.

Unlike the U.S. scenario, two regions (Prince Edward Island and Newfoundland) with small populations had only one BIP in operation per province with no plans for developing guidelines. The mission statement and protocol governing each of those batterer programs hence could be regarded as composing standards for the entire province, but were not included in the analysis for this study.

CONCERNS LINKED WITH CANADIAN BIP STANDARDS

Whereas our inquiry did not identify controversies to be as contentious or as widespread as in the U.S., we did note some concerns regarding Canadian standards, particularly in the provinces of British Columbia, Saskatchewan, and Quebec.

Some battered women's advocates and batterer facilitators (counsellors working with batterers) in BC expressed their concern that the province's guiding principles devote inordinate attention to batterer rehabilitation and thus, in their view, detract from the project of social change for the safety and well-being of women and children. In other words, an incongruity between rehabilitating batterers and the interests of victims is evidently felt by some who are working with both, suggesting a need for greater community collaboration involving all stakeholders when the standards are next revisited.

Those developing a set of BIP standards in SK were grappling with whether persons should be accepted into a batterer intervention program who have pending criminal charges and whether using family or couples counselling formats should be permissible. Some people found it troubling that BIPs may become a means by which the accused can escape punishment for the crime committed if the programs are allowed to divert the batterer away from legal sanction. The additional concern voiced by respondents was that a person accused of assault may implicate the program's participants to testify in court for the Crown or, worse, for the defense.

TABLE 2

Summary of Canadian BIP Standards by Region*

Province/Territory	Content
	History and Development of Standards
CSC	Acknowledges using the BC standards as a principal reference for its own text
BC, QC	Provide background information about their development Included in developing standards were: women's service, justice system, spousal assault coordinating committees, immigrant services, and the provinces's existing batterer programs
NS	Does not discuss the development of its standards, but it (like BC and QC) lists the names and affiliations of those involved in their development
	Purpose of Standards
CSC	To "reduce family violence within the offender populations by identifying suggested program content and process"
BC	To promote "quality consistency amongst batterer programs" and to assist new programs and funding sources to meet "a minimum clinical standard"
QC	To give recognition to services and specify inter-agency collaboration
ON	To support "the implementation of interim accountability and accessibility requirements for male batterer programs contracting with government ministries"
	Program Objective(s)/Philosophy and Problem Definition
CSC, BC, QC, SK, YK	Abuse defined as both physical and psychological injury
BC, SK, YK	All violence stems from combined "patriarchal/social and personal/relational deficits requiring anger-management and learning social skills" Prioritize victim safety in all interventions and caution about limitations of BIPs in reducing or stopping the violence
QC	Domestic violence exists in the context of a social problem of women dominated by men
CSC	Change "gender-based beliefs and behaviours and confront gender-based attittudes and thinking patterns which contribute to violence"

TABLE 2 (continued)

Summary of Canadian BIP Standards by Region*

CSC (continued)	"Integrate social and learning theories along with power and control (pro-feminist) theories"
BC, YK	Show "respect and care" for batterers because this is "fundamental to the process of change"
SK	Men's violence against women is a "public and community issue" rather than a private matter
NS	Responsibility of community to not tolerate the violence
CSC, BC, NS, ON, YK	Intervention should be "culturally specific" or "culturally relevant" (unspecified further)
	Program Duration, Format, and Mode
CSC, BC, NS, SK, YK	Group intervention the preferred format Couples counselling potentially dangerous for victims and inappropriate as initial or principal format
QC	Advisable to use group format
CSC	Preferred model to be combined "cognitive-behavioural and pro-feminist" lasting 4 months (of 2- to 3-hour weekly sessions)
CSC	"Longer" (unspecified) programs more effective than brief, time-limited ones Discourage use of "unstructured self-help groups" as a primary treatment modality
	Program Curriculum and Practice Techniques
BC, YK	Address anger awareness, control issues, re-socialization, family-of-origin issues, stress, and social isolation Confront destructive beliefs, behaviours, attitudes, and thinking patterns Employ techniques that reduce denial and minimization Promote awareness of abuse, gender bias, and non-sexist attitudes
CSC	"Explore underlying issues related to abusive behaviours without allowing denial of personal responsibility for abuse" Avoid using ventilation ("fair fight") techniques Avoid anger-management instruction "without working on power issues"

TABLE 2 (continued)

Summary of Canadian BIP Standards by Region*

	Program Protocol: Strategies and Tasks for Outreach, Collaboration, and Partner Safety
CSC, BC, NS, ON, QC, SK, YK	Collaborate with collateral resources (e.g., justice system, victim services, shelters, mental health, etc.)
CSC, BC, NS, ON, SK, YK	Client (batterer) confidentiality limited to allow program staff to communicate with victim, victim services, and justice system
CSC, BC, ON, SK, YK	Programs must undertake partner contacts
BC, QC, SK, YK	Programs should focus on public education, promote social change activities (unspecified) Battered women's resources are a pre-requisite to effective counselling with batterers, and without them BIPs should not be providing services
BC, SK, YK	Programs not to accept clients (batterers) with outstanding criminal charges pending so as to avoid program manipulation by defense lawyers, or program misuse as diversionary options to legal sanction
	Program Protocol: Intake, Assessment, Client Contracting, Referral, and Terminating Services
CSC, BC, NS, YK	Assess lethality of batterers Screen for "mental health problems"
CSC, BC, ON, SK, YK	Written contract with batterer specifying: attendance/participation requirements Protocol for partner safety checks; limitations on confidentiality; commitment to cease violence; not abuse alcohol or other drugs
BC, YK	Gives criteria (including repeated use of violence, poor attendance/participation, and untreated substance abuse) for screening out those inappropriate for BIP intervention and for terminating batterers already in program
	Program Protocol: Staff Ethics and Staff Qualifications
CSC	"Education" and "certification" (unspecified) for staff should be considered, but more crucial is: (a) "interest in the role that societal attitudes and sex-role stereotyping play in contributing to abuse;" (b) facilitator's capacity to relate "positively and empathically to clients" while also "confronting them without demeaning them;" (c) enthusiasm, humility, and flexibility in considering new ideas;

TABLE 2 (continued)

Summary of Canadian BIP Standards by Region*

CSC (continued)	(d) possessing group facilitation skills, especially with "poorly motivated clients"
BC	"Former abusers can be useful staff members, but must be given support and opportunity to continue their recovery"
BC, YK	Program facilitators should be "trained clinically," have experience in group counselling, be familiar with family violence literature, and "have resolved personal issues" (unspecified further) Ongoing support and supervision for staff required
NS	Facilitators to adhere to a "feminist" philosophy which includes: not behaving in ways that perpetuate sexist attitudes; being violence-free; not abusing alcohol or drugs; and, not having perpetrated any crimes during past year in which violence was used Service providers should "demonstrate an appropriate level of understanding regarding issues of family violence and counselling intervention skills," and participate in regularly scheduled training to support continued learning/development
	Program Evaluation and Accountability
CSC, BC, NS, QC, SK, YK	Specify that batterers must take responsibility and be accountable for their violence
CSC, BC, QC, YK	BIPs are to receive input from battered women and their advocates
ON, SK	Make themselves "accountable to battered women and their advocates"
CSC, BC, NS, YK	Programs should be evaluated or have evaluation mechanisms in place (unspecified as to what this entails and who should conduct study)
CSC	Psychological research on borderline personalities is a "significant complement" to social learning theory and power/control theory

Legend: CSC = Correctional Service Canada; BC = British Columbia; ON = Ontario; QC = Quebec; SK = Saskatchewan; NS = Nova Scotia; YK = Yukon

* Where a province or territory is not identified, the respective standards for that region were silent on the theme in question. Correctional Service Canada (CSC) standards are included, though jurisdiction extends nationally, albeit for a circumscribed population.

In QC, battered women's shelters, in their continued efforts to express their concerns about certain batterer-program practices and how they are funded, evidently are relying on an inter-ministerial (provincial) domestic-violence policy

rather than existing standards specifically created for BIPs.[5] An unpublished position paper prepared by an association of transition houses in Quebec (Régroupement provinciale des maisons d'hébergement et transition des femmes victimes de violence conjugal, 1997), noted the following: (a) Some BIPs appeared to be working with batterers from a "traditional psychological approach" rather than from an approach which emphasizes more batterer accountability; (b) Funding for these programs should come from the ministry responsible for the public's safety rather than from the one which currently funds victims' services; and (c) This funding should be conditional, based upon a program's compliance with the aforementioned inter-government policy. In sum, the issues here revolve around a concern that the curricula of many programs are not adequately focused on the perpetrator's abuse, and that funding for BIPs should not be juxtaposed with funding for victims' services, especially shelters for battered women.

DISCUSSION AND CONCLUSIONS

As in the U.S., the trend to develop standards for batterer-intervention programs in Canada is well under way. These standards, along with the process which leads up to their creation, appear to be achieving the objective of bringing a degree of uniformity to the field, based on similar conceptualizations about domestic violence and how best to end it. Standards are generally alike across the country and resemble those developed in the U.S.; they characterized domestic violence as the abuse of power and control against women, who are entrenched in patriarchal society. Nonetheless, several standards do make additional reference to skill deficits and anger management as relevant to any sound treatment strategy.

Canadian standards can be said to constitute beacons for those navigating in a relatively new field, and may be especially useful to those who are developing new programs and seeking guidance as they implement services for the first time. Moreover, standards appear in some cases specifically to serve policy-makers and funders, providing templates for contracting and program reviews. Both of these aspects appear to be compelling reasons for regions that have not yet done so to consider developing standards.

The widely practised policy of requiring batterers to pay fees for services is not indicated in Canadian standards. In the U.S., this often is advanced as one additional way to enhance responsibility for personal behavior—that is, batterers should be paying a fee in line with the notion of restorative justice. It is evident, however, that such a policy is likely to be more difficult to implement within Canada's universally accessible and comprehensive health-care system than within the two-tier, for-profit system in the U.S. In QC, for example, a number of batterer programs are a service of unionized local community service centres (CLSCs) which, on principle, eschew the fee-for-service formula because it is seen to encroach on universal access (and workers' benefits).

There are additional differences to be found between U.S. and Canadian standards. For example, program duration often is stated explicitly in U.S. standards but omitted in Canadian directives. Canadian standards do not specify program completion requirements, yet many in the U.S. state that batterers must have completed the required number of sessions and additionally be free of violence

for a specified period of time. It may be advantageous for Canadian standards to specify minimum duration and completion criteria as a way to counter any development of highly dubious programs simply offering correspondence courses and weekend retreats for batterers—a phenomenon which has already occurred in the U.S.

The matter of monitoring or overseeing compliance with standards is generally weak in both countries. Where standards are mandatory in Canada, they are so only by virtue of programs entering into contracts with government funders, and it is solely the contractor who monitors compliance via audits or other occasional site visits. Although monitoring for compliance entails added human resources, without monitoring there is no way to assess whether programs are following standards.

Canadian standards (like those in the U.S.) do not specify how to intervene with women who increasingly are being arrested for domestic violence assaults, even while studies suggest the vast majority of them are victims of domestic abuse who are self-defending or retaliating against their batterer (Hamberger & Potente, 1994; Marshall & Rose, 1990; Saunders, 1986). Such referrals to BIPs warrant, in our view, particular directives so as to ensure these women are not unwittingly re-victimized in groups of batterers. Similarly, all standards should be providing information on intervening with gay and lesbian offenders as well as offering substantive content on culturally competent practice with particular populations such as First Nations and Inuit.

Finally, it may be instructive for standards to delineate how victim safety and program accountability might be operationalized. Because of the detail devoted to safety and accountability with corresponding indicators on its checklist, Ontario's standards may be exemplary for this task. Confusion over program mode in labels such as "psycho-educational" or "feminist" might be resolved with a more detailed description of how safety, accountability, and attention to power and control issues are to be achieved through the curriculum and structure of a program. Such explications also could require exploring how monitoring for compliance with standards can be improved and conducted in a manner which includes the participation of victims' advocates.

Although this exploration of Canadian BIP standards suggests fewer concerns in regulating interventions with batterers than in the U.S., the essence of the controversy now occurring in U.S. jurisdictions should be examined and carefully considered for possible implications in Canada. Perhaps, in doing so, some of the more contentious issues can be addressed before they become as polarized. For example, to help reduce tensions between professionals and activists, and to deconstruct dichotomies between therapy and social control and social change, perhaps standards could recommend a "both and" rather than "either or" position in a number of areas. Both clinical skills training and knowledge of the practical implications of tackling a social problem rooted in patriarchy can be acknowledged as viable and congruent.

It is our view that standards for batterer programs can continue to be an important initiative towards stopping domestic violence—if they are developed in a manner which is inclusive of all key resources within the domestic-violence community, and if they give explicit recognition for periodic revision based upon new information from research and practice experience. Future research might

explore the impact standards have in a given region, similar to current endeavors in Illinois and Texas. As we stated in our review of U.S. standards (Austin & Dankwort, 1999), we believe that batterer accountability and victim safety should always be the criteria against which any changes in batterer intervention standards are considered. Before we jettison our current practice, based on decades of experience and recorded through standards, the gains in adopting alternatives first must appear convincing to those "in the trenches" who first signalled the prevalence and seriousness of domestic violence.

NOTES

1. The questions asked were the following: (a) Are there any standards or guidelines in existence or planned for batterer intervention programs in your province (or territory)? (b) If so, could you tell me something about how these standards were developed and who or what agencies, groups, organizations, and departments were involved? (c) Was there or is there any controversy about such (planned) standards that you are aware of? A copy of each set of standards or draft was requested to be sent by mail. If respondents could not provide answers, they then were asked who might be able to do so, and subsequent calls based on that information were made until researchers felt confident queries had been sufficiently probed.
2. Batterer program diversity is reflected partly in differing names programs give themselves. For example, some forego using the word "treatment" as overly "psychologizing" battering and prefer to see themselves as educational projects to have batterers take responsibility and become accountable to battered women and the wider community.
3. Although Canadian regions appear to be using the terms "guidelines" or "principles," "standards" is used in this report as a generic term to include all regulations in conformity with other authors writing on the topic.
4. What distinguished Ontario's standards is that they were written specifically to serve the purpose of a compliance review checklist for ministry staff contracting with agency service providers and are limited to three topics: safety measures, program accountability strategies, and program accessibility requirements.
5. It is not clear why existing BIP guidelines are not being used as a template for proposed changes, but one respondent speculated that the inter-ministerial policy has legislative authority which Quebec's guidelines lack.

RÉSUMÉ

Cet article examine la tendance croissante à l'uniformisation dans les programmes d'intervention auprès des conjoints violents. Une étude a été menée à l'échelle du Canada afin d'identifier toutes les normes existantes, leur mise en oeuvre dans les programmes d'intervention et les controverses éventuelles qui ont entouré leur élaboration. Après un bref historique de l'intervention auprès de cette clientèle et de l'élaboration des normes dans les programmes nord-américains pour conjoints violents, l'article décrit les différents types et le contenu des normes canadiennes avant de proposer, en conclusion, une discussion des résultats ainsi que des suggestions pour l'amélioration de ces normes. L'observance des normes était obligatoire dans deux régions et facultative dans trois autres. Deux autres régions étaient en train d'élaborer des normes. Dans ces différentes normes se retrouvaient certains éléments typiques tels que des lignes conductrices sur les objectifs généraux des programmes, les protocoles et procédures à suivre, notamment on ce qui concerne le genre de counselling, et la déontologie ainsi que les qualifications du personnel impliqué dans les programmes.

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