
COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD

STANDARDS AND GUIDELINES FOR THE ASSESSMENT, EVALUATION, TREATMENT, AND BEHAVIORAL MONITORING OF DOMESTIC VIOLENCE OFFENDERS



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Division of Criminal Justice
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Management

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COLORADO
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1.0 Domestic Violence Offender Management Board

1. Introduction to the Domestic Violence Offender Management Board

The Colorado Domestic Violence Offender Management Board (hereafter Board) was created by the General Assembly in the Colorado Department of Public Safety in July 2000 pursuant to § 16-11.8-103, C.R.S. The legislative declaration in the Board’s enabling statute states that the consistent and comprehensive evaluation, assessment, treatment and continued monitoring of domestic violence offenders at each stage of the criminal justice system is necessary in order to lessen the likelihood of re-offense, to work toward the elimination of recidivism and to enhance the protection of current and potential victims (§ 16-11.8-101 C.R.S.)¹. The Board was charged with the promulgation of standards for the evaluation, assessment, treatment, and monitoring of domestic violence offenders defined in § 16-11.8-102, C.R.S. (hereafter *Standards and Guidelines*) and the establishment of an application and review process for approved providers who provide services to domestic violence offenders in the state of Colorado. The evaluation, assessment, treatment, and behavioral monitoring of domestic violence offenders shall only be provided by those individuals whose name appears on the DVOMB Approved Provider List pursuant to § 16-11.8-104(1).

The Board is committed to carrying out its legislative mandate to enhance public safety and the protection of victims and potential victims through the development and maintenance of comprehensive, consistent and effective standards for the evaluation, assessment, treatment and behavioral monitoring of adult domestic violence offenders. The Board will continue to explore the developing literature and research on the most effective methods for intervening with domestic violence offenders and to identify best practices in the field.²

1.01 Purview of the DVOMB

- I. Pursuant to § 16-11.8-103(4)(a)(II) C.R.S., the DVOMB *Standards and Guidelines* apply to adult domestic violence offenders who have committed a crime, the underlying factual basis of which has been found by the court on the record to include an act of domestic violence, and who are placed on probation, placed on parole, or placed in community corrections (i.e. direct sentence, DOC inmates occupying state funded community correction beds), or who receive a deferred judgment and sentence.³ The DVOMB *Standards and Guidelines* apply to post-conviction and pre-sentence offender evaluations.⁴ Domestic violence convictions pursuant to local municipal codes are not explicitly included in the DVOMB statutory mandate, but evaluation and treatment pursuant to the *Standards and Guidelines* can inform these cases as a guide.
- II. There may be other individuals in need of evaluation, assessment, treatment, and

¹ Although the term assessment does not appear in § 16-11.8-101, the DVOMB has included this term as part of the treatment process defined by the DVOMB Standards and Guidelines pursuant to § 16-11.8-102(4).

² For more information about the Board, membership, and mandates, please see the DVOMB By-laws.

³ Pre-plea matters are not subject to the purview of the DVOMB Standards and Guidelines.

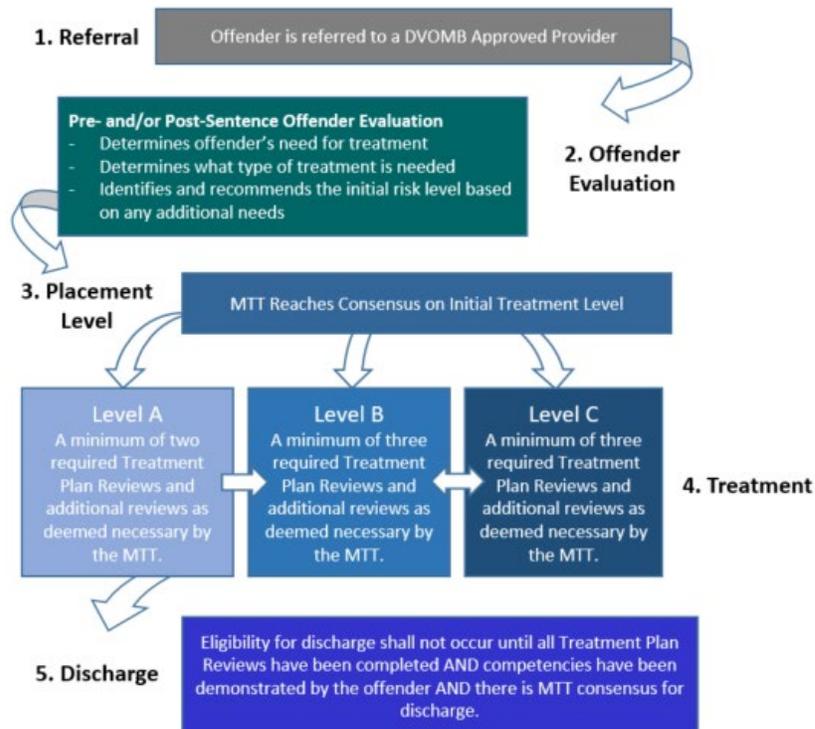
⁴ C.R.S.18-6-801(1)(b), *Partners in Change v. Domestic Violence Offender Management Board*, within the Division of Criminal Justice of the Department of Public Safety of the State of Colorado, Case Number 06cv10083

supervision who do not meet the statutory definition of a domestic violence offender or are not under the jurisdiction of the Colorado criminal justice system. Approved Providers should consider the use of the DVOMB *Standards and Guidelines* as a best practice guideline and at their discretion for cases that do not fall under the purview of the DVOMB. For more information, please see Appendix A.

- III. The DVOMB *Standards and Guidelines* use a variety of terms referencing persons who are subject to these Standards. The terms that are frequently used in the Standards include domestic violence offender, offender, and client. These terms of reference are used in different sections of the Standards based on the focus of a given section (e.g., treatment, supervision, etc.), as well as the preferred language of professional stakeholders who frequently reference that section. The DVOMB notes that the use of the term ‘domestic violence offender’ is consistent with the statutory definition identifying a person who committed a crime, the underlying factual basis of which has been found by the court on the record to include an act of domestic violence. However, the DVOMB recognizes that the use of the term domestic violence offender is in no way intended to label individuals by their behavior, or suggest that those who undergo treatment cannot live a violence and abuse free life-style.

1.02 General Overview of the Evaluation and Treatment Process

- I. Upon order by the Court or Parole Board, an offender is required by statute to receive an evaluation and attend treatment as recommended.⁵ The offender evaluation will result in treatment recommendations that assess the offender’s need for treatment, determine what type of treatment is needed, and identify the initial risk level and any additional needs the offender may have related to containment, stabilization and safety (Section 4.0). Please refer to the Figure 1 below for a visual depiction of this process.



⁵ C.R.S. 18-6-801(1)(a)

- II. Treatment is the comprehensive set of planned therapeutic experiences and interventions designed to assist the offender in changing any power and control dynamics, abusive thoughts, and behaviors (Section 5.01). Treatment requires the offender to attend in-person group or individual sessions at a minimum of once a week or more depending on the offender's treatment level (Section 5.03). Treatment is individualized and progress is assessed during a Treatment Plan Review (TPR), which occurs every two to three months (Section 5.07). The degree to which an offender progresses in treatment and remains compliant is based on meeting goals associated with the core competencies rather than the passage of a specific amount of time or sessions (Section 5.08).
- III. Progress through treatment and victim safety is monitored by the Multi-Disciplinary Treatment Team (MTT) consisting of the Approved Provider, the supervising officer, a Treatment Victim Advocate (Section 7.0), and any other adjunct member of the MTT (Section 5.02). The MTT communicates regularly and shares information about the offender during the course of treatment in order to mitigate risks, support accountability, and improve victim safety. At the conclusion of treatment and as required by the Standards, an offender can be discharged as complete, unsuccessful, or administratively (Section 5.09).

Acknowledgement and Dedication, February 7, 2008

The Domestic Violence Offender Management Board and the Division of Criminal Justice hereby acknowledges Gary Burgin, probation supervisor for the 18th Judicial District state probation office, for his dedication and continual commitment to ending domestic violence. Gary worked on various projects with the DVOMB for many years. Most recently, he participated on the DV Treatment Review Committee. Gary's leadership on this committee promoted professional collaboration. Gary's refusal to minimize abuse in any context and his expertise regarding the management and containment of offenders has been invaluable. He quickly became known as the "gold standard" for probation goals and ideals. He unified and inspired the committee with his endless perseverance to create a new, more effective treatment model for domestic violence offenders. Gary's contributions have--and will continue to have--impact on the *Standards and Guidelines for Domestic Violence Offenders*.

2.0 Historical Perspective

Domestic violence offenders were treated on a voluntary basis prior to 1979, as no formal court referral system existed. In 1979, the Jefferson County District Attorney’s Office in conjunction with Women in Crisis began a domestic violence program for individuals criminally charged. The following year, Alternatives to Family Violence, an Adams County treatment program, assisted in the development of a referral system for offenders from municipal court; however, there were no formal standards governing the treatment of those who were referred.

In 1984, the Denver Consortium helped institute a mandatory arrest policy in Denver. As a result of increased arrests, additional offenders were referred for treatment increasing the need for providers to work with domestic violence offenders. Community members, including representatives of victim services, treatment agencies, and the criminal justice system, became concerned that the treatment provided to these offenders was inconsistent.

As a result of these concerns, a statewide committee on intra-agency standards was formed that included both urban and rural groups. Experts in the field of domestic violence contributed information to the committee. In 1986, written treatment standards were completed and approved by the Service Provider’s Task Force, a subcommittee of the Colorado Coalition Against Domestic Violence, formerly the Colorado Domestic Violence Coalition.

In 1987, Representative John Irwin, with support of the domestic violence community, successfully proposed a law mandating treatment for all people convicted of a crime with an underlying factual basis of domestic violence (§18-6-803, C.R.S.). In addition to mandated treatment, the new law established the State Commission, appointed by the Chief Justice of the Colorado Supreme Court to create standards for treatment, and provide for appointment of certification boards in each judicial district. These local boards were charged with certifying and monitoring approved providers’ compliance with the *Standards and Guidelines*.

The new law had two major shortcomings, creating tensions that ultimately led to the dismantling of the law. First, no funds were allocated to support the effort of the State Commission and the local certification boards. Secondly, some licensed mental health professionals objected to the local certification board process, believing that it created a “double jeopardy” situation. Both the local certification boards and the Colorado State Department of Regulatory Agencies regulated the professionals. In response to these concerns, Representative Steve Toole proposed HB 1263 in the 2000 legislative session. Effective July 1, 2000, Section 16-11.8-101, et. seq., C.R.S. established the Domestic Violence Offender Management Board that is responsible for promulgating standards for treatment and establishing an application process for treatment providers. Section 16-11.8-101, et. seq., C.R.S. authorizes the Colorado mental health licensing boards and the Department of Regulatory Agencies to approve treatment providers in conjunction with the Domestic Violence Offender Management Board (Board). The Board commends the General Assembly for recognizing domestic violence, a long-standing social problem as a crime, and enacting proactive legislation.

3.0 Guiding Principles

The treatment of offenders in the State of Colorado employs a variety of theories, modalities, and techniques. Domestic violence offenders are a separate category of violent offenders requiring a specialized approach. The primary goals are cessation of abusive behaviors and victim safety.

It is the philosophy of the Domestic Violence Offender Management Board that setting standards for domestic violence offender approved providers alone will not significantly improve public safety. In addition, the *process* by which domestic violence offenders are assessed, treated, and managed by the criminal justice system and social services systems should be coordinated and improved.

Domestic violence offender treatment is a developing field. The Board will remain current on the emerging research and literature and will modify these *Standards and Guidelines* based on an improved understanding of the issues. The Board must also make decisions and recommendations in the absence of clear research findings. Therefore, such decisions will be directed by the Guiding Principles, with the governing mandate being the priority of public safety and attention to commonly accepted standards of care. Additionally, the Board will endeavor to create state standards that reflect that Colorado communities have unique geographic features, challenges, and resources.

These Guiding Principles are designed to assist and guide the work of those involved in the management and containment of domestic violence offenders.

KEY CONCEPTS:

Management: The management of domestic violence offenders involves the knowledgeable, accountable participation of law enforcement, victim services, advocates, the DVOMB and all systems involved such as mental health, substance abuse services, and child protection services. In order to manage domestic violence offenders and to reduce and ultimately eliminate domestic violence, a coordinated community response is required, thus offender containment is one element of offender management.

Containment: The preferred approach in managing offenders is to utilize a containment process. Those involved in the containment process are directly responsible for holding offenders accountable while under supervision of the court. This includes, but is not limited to: the courts, the supervising agents of the court, such as probation, and the approved providers. While these *Standards and Guidelines* require approved providers to communicate, collaborate, and consult with the rest of this containment group, this concept of containment and communication should be strived for by the courts and supervising agents of the courts as well.

GP 3.01 Victim and community safety are paramount.

Victim and community safety are the highest priorities of the *Standards and Guidelines*. This should guide the system responses of the criminal justice system, victim advocacy, human services and domestic violence offender treatment. Whenever the needs of domestic violence offenders in treatment conflict with community (including victim) safety, community safety takes precedence.

GP 3.02 Domestic violence is criminal behavior.

GP 3.03 The management and containment of domestic violence offenders requires a coordinated community response.

The Board encourages the development of local coalitions/task forces to enhance inter-agency communication and to strengthen program development.

All participants in offender management are responsible for being knowledgeable about domestic violence and these *Standards and Guidelines*. Open professional communication confronts offenders' tendencies to exhibit secretive, manipulative, and denying behaviors. Only in our aggregate efforts, applying the same principles and working together, can domestic violence offender management be successful.

Other involved professionals such as mental health providers, substance abuse counselors and health care professionals bring specialized knowledge and expertise.

Information provided by each participant in the management of an offender contributes to a more thorough understanding of the offender's risk factors and needs, and to the development of a comprehensive approach to treating and containing the offender.

Decisions regarding the treatment of domestic violence offenders shall be made by the containment group.

GP 3.04 Successful management and containment of domestic violence offenders are enhanced by increased public awareness of domestic violence issues.

The complexity and dynamics of domestic violence are not yet fully understood and many myths prevail. These myths inhibit proactive community responses to domestic violence. Knowledgeable professionals have a responsibility to increase public awareness and understanding by disseminating accurate information about domestic violence. This may facilitate communities to mobilize resources and to effectively respond to domestic violence.

GP 3.05 There is no singular profile of a person who commits acts of domestic violence.

People who commit acts of domestic violence vary in many ways such as age, race and ethnicity, sexual orientations, gender identities, gender, mental health condition, profession, financial status, cultural background, religious beliefs, strengths and vulnerabilities, and levels of risk and

treatment needs. People who commit abusive offenses may engage in more than one pattern of offending and may have multiple victims.

GP 3.06 It is the nature of domestic violence offenders that their behaviors tend to be covert, deceptive, and secretive.

These behaviors are often present long before they are recognized publicly.

GP 3.07 Domestic violence behavior is dangerous.

When domestic violence occurs, there is always a victim. Both literature and clinical experience suggest that this violence and/or abuse can have devastating physical, emotional, psychological, financial and spiritual effects on the lives of victims and their families. Offenders may deny and minimize the facts, severity, and/or frequency of their offenses. Domestic violence offenders often maintain a socially-acceptable facade to hide their abusive behaviors. At its extreme, domestic violence behavior can result in the death of the victim, offender, family members, and others.

GP 3.08 Domestic violence behavior is costly to society.

Domestic violence has significant economic impact on various individuals and groups, including but not limited to, the victim, family and offender, schools, business and property owners, faith communities, health and human services, law enforcement and the criminal justice system.

GP 3.09 All domestic violence behavior is the sole responsibility of the offender.

GP 3.10 Offenders are capable of change.

Responsibility for change rests with the offender. Individuals are responsible for their attitudes and behaviors and are capable of eliminating or modifying abusive behavior through personal ownership of a change process. Ideally, this includes cognition, affect, and behavior. Treatment enhances the opportunity for offender change. Change is based on the offender's motivational levels and acceptance of responsibility. Motivation for change can be strengthened by effective treatment and community containment.

GP 3.11 Assessment and evaluation of domestic violence offenders is an on-going process.

Because of the cyclical nature of offense patterns and fluctuating life stresses, domestic violence offenders' levels of risk are constantly in flux. Changes that occur as a result of the supervision or treatment of offenders cannot be assumed to be permanent. For these reasons, continuous monitoring of risk is the joint responsibility of the responsible criminal justice agency and the approved provider. The end of the period of supervision should not necessarily be seen as the end of dangerousness.

GP 3.12 Domestic violence offender treatment differs from traditional psychotherapy.

In traditional psychotherapy, the client engages in a voluntary therapeutic relationship with a therapist of his/her choice, based largely on goals and purposes decided by the client. Court ordered offender treatment differs from traditional therapy in the following ways:

- Treatment is not voluntary. A therapeutic alliance is not a prerequisite for treatment.
- The offender enrolls in treatment at the court's direction, and sanctions are applied for failure to participate.
- The offender must receive treatment only from providers approved by the state to provide the treatment.
- Individual treatment goals are determined by the therapist to reduce recidivism and increase victim and community safety.
- Decisions regarding treatment and containment are made jointly between approved providers and criminal justice agencies.
- Approved providers are required to consult and communicate with the victim advocate and other involved agencies.
- Confidentiality is limited by the requirements of the criminal justice system and the needs of victim safety.
- Victim advocacy is an essential component of offender treatment.
- Minimization and denial of the need for treatment is expected, and therefore, treatment involves the challenging of the offender's perceptions and beliefs.

GP 3.13 The preferred treatment modality is group therapy.

GP 3.14 Victims have a right to safety and self-determination.

Victims of domestic violence undergo tremendous turmoil and fear as a result of the violence inflicted. Their feelings and their potential for further harm should always be afforded the utmost consideration.

Victims have the right to determine the extent to which they will be informed of an offender's status in the treatment process and the extent to which they will provide input through appropriate channels to the offender management and treatment process.

GP 3.15 Offender treatment must address the full spectrum of abusive and controlling behaviors associated with domestic violence, and not just the legally-defined criminal behavior(s).

GP 3.16 Domestic violence offender assessment, evaluation, treatment and behavioral monitoring should be non-discriminatory and humane, and bound by the rules of ethics and law.

Individuals and agencies carrying out the assessment, evaluation, treatment and behavioral monitoring of domestic violence offenders should not discriminate based on race, religion, gender, gender identity, sexual orientation, disability, national origin or socioeconomic status. Domestic

violence offenders must be treated with dignity and respect by all members of the team who are managing and treating the offender regardless of the nature of the offender's crimes or conduct. Individual differences should be recognized, respected and addressed in treatment.

GP 3.17 Treatment programs shall strive to have staff composition reflect the diversity of the community they serve.

4.0 Offender Evaluation

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The purpose of a domestic violence offender evaluation (hereafter offender evaluation) is to assess the offender’s need for treatment, determine what type of treatment is needed, and identify the risk level and any additional needs the offender may have related to containment, stabilization and safety. While the evaluation provides valuable information and recommendations, and as new information emerges, or risk level changes within the course of treatment, an offender’s treatment should be tailored to address those changes.⁶ Each offender shall receive a thorough assessment and evaluation⁷ that examines the interaction between the offender’s mental health, social/systemic functioning, family and environmental functioning, and offending behaviors. Evaluators have an ethical responsibility to conduct evaluations in a comprehensive and factual manner, regardless of the offender’s status within the criminal justice system. Consequently, evaluators will prioritize the physical and psychological safety of victims and potential victims in making recommendations that are appropriate to the assessed risk and needs of each offender.

4.01 Referral for Offender Evaluation Services:

- I. If a criminal justice agency⁸ makes a referral to an Approved Provider, that Approved Provider shall notify the criminal justice agency if the offender does not make contact within the time frame indicated. If no time frame was included with the referral, the Approved Provider shall notify the criminal justice agency within one week if the offender does not contact the Approved Provider.

Discussion Point: It is considered a best practice for the criminal justice supervising officer (or agent) to provide as much information as possible to the Approved Provider when the referral is made. Collateral information such as the police report, prior evaluations, the results to the Domestic Violence Screening Instrument (DVSI) and/or the Level of Service Inventory, a summary of the offender’s criminal history, and any other documentation should be provided when available and applicable. The availability of collateral documentation helps Approved Providers start the evaluation process.

- II. Initial Appointment - After the offender has made contact with the Approved Provider, the Approved Provider should make all reasonable attempts to schedule the initial appointment with the offender within one week of being contacted by the offender. If the Approved Provider is not able to schedule an initial appointment within a reasonable time, the Approved Provider shall communicate with the supervising officer or agent for next steps.
- III. Interstate Compact Requirements - Pursuant to § 17-27.1-101, C.R.S, Approved Providers shall notify the Colorado Interstate Compact Office whenever an out-of-state offender enrolls in a domestic violence offender treatment program. This applies to all offenders who have been convicted of or have agreed to a deferred judgment, deferred sentence, or deferred prosecution for a crime in another state. The Approved Provider may complete the offender evaluation, but may not start domestic violence offender treatment until approval has been granted by the Colorado Interstate Compact Office.

⁶ Bonta, J., & Wormith, J. S. (2013). Applying the risk-need-responsivity principles to offender assessment. In L.A. Craig, L. Gannon, L., & T. A. Dixon (Eds.), What works in offender rehabilitation: An evidence-based approach to assessment and treatment (pp. 71–93). Hoboken, NJ: Wiley-Blackwell.

⁷ Each evaluation shall be sensitive to the functioning, skills, and mental and physical capabilities of each offender.

⁸ Probation, private probation, parole, community corrections, or diversion.

- IV. Refusal to Admit - Approved Providers shall provide written documentation with reasons for refusal to admit to treatment to the responsible criminal justice agency within one week.

4.02 Parameters of the Offender Evaluation

- I. The offender evaluation shall not be used to determine guilt or innocence, or whether or not an act of domestic violence has occurred as the offender has already pled guilty to, or has been convicted of a domestic violence offense.

Discussion Point: The criminal justice system, not the Approved Provider, is responsible for making legal decisions regarding guilt or innocence, pleas, convictions, and sentencing. When a pre- or post-sentence evaluation is conducted, the presumption is that the offender is guilty and will complete domestic violence offender treatment per the Standards and Guidelines. Evaluations performed prior to a finding of guilt (e.g., pre-plea, conviction, etc.) may not meet the requirements of these Standards and Guidelines. As such, Approved Providers may need to create an updated evaluation as an addendum to any previously performed evaluation that does not meet the DVOMB Standards and Guidelines.

- II. The offender evaluation shall be used to develop baseline measures in order to assess offender gain, lack of progress, or regression with regard to criminogenic need and risk of re-offense.
- III. Evaluation(s) shall direct initial placement of the offender into the appropriate level and intensity of treatment as identified in *Standard 5.06*.
- IV. Approved Providers shall not represent or imply that an offender evaluation meets the criteria for a domestic violence offender evaluation if it does not comply with the DVOMB *Standards and Guidelines*. Approved Providers shall include a statement in each completed evaluation as to whether the evaluation is fully compliant with the DVOMB *Standards and Guidelines* or not.
- V. Specific goals of the evaluation shall assess and determine the following:
- Level and nature of risk, including possible lethality for future domestic violence⁹ (Reference Appendix E, Section VII);
 - Individual criminogenic needs¹⁰, domestic violence, and issues related to power and control (Reference Appendix E, Section IV);
 - Strategies for managing criminogenic needs and the presence of any domestic violence and issues related to power and control;
 - Offender strengths (e.g., pro-social support factors, employment, education);
 - Any potential destabilizing factors (e.g., job loss, homelessness, bankruptcy);
 - Offender responsivity factors (Reference Appendix E, Section VI);
 - Level of offender accountability (Reference Appendix E, Section I);

⁹ Campbell, J. C. (2005). Assessing dangerousness in domestic violence cases: history, challenges, and opportunities. *Criminology and Public Policy*, 4, 653–672.

¹⁰ Hilton, Z. & Dana L. Radatz, D. (2018). The Criminogenic and Noncriminogenic Treatment Needs of Intimate Partner Violence Offenders *International Journal of Offender Therapy and Comparative Criminology*, 62(11) 3247–3259.

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- Assessment of amenability¹¹ for treatment is defined as:
 - The ability to comprehend treatment concepts
 - The physical and mental ability to function in a treatment setting
 - The presence of potential language barriers (see Standard 5.03 for more information).
- Considerations and clinical factors unique to a Specific Offending Population (e.g., female offenders, LGBQIA+ offenders) using the guidelines from Appendix B;
- Relevant diagnostic considerations regarding the treatment of co-existing conditions, the need for medical or pharmacological treatment (if indicated), and further assessments needed to address areas of concern;
- Overall clinical issues and criminogenic needs in the form of a case conceptualization and make recommendations for the Offender Treatment Plan;
- Recommendations of initial strategies for monitoring related to community and victim safety.

***Discussion Point:** The Standards and Guidelines do not preclude an Approved Provider from performing an evaluation as well as the treatment for the same offender.*

4.03 Pre-Sentence Offender Evaluation (PSE)

The purpose of a presentence evaluation (PSE) is to provide the court with relevant information upon which to base sentencing decisions. The domestic violence offender evaluation establishes a baseline of information about the offender’s risk and protective factors, treatment needs and recommendations, and amenability to treatment. The PSE may include recommendations about an offenders’ suitability for community supervision.

- I. A PSE shall only be conducted by an DVOMB Approved Pre-Sentence Evaluator.
- II. The PSE is not a required evaluation for offenders. A Pre-Sentence Evaluator may perform a PSE to obtain information that will provide treatment recommendations related to domestic violence and dynamics of power and control, results of any additional psychological testing, strategies for offender containment, monitoring, and supervision requirements based on assessments of an offender’s risk, needs, and responsibility.¹² The PSE shall comply fully with the *Standards and Guidelines*, specifically 4.02, 4.05, 4.06, 4.07 and Appendix E of which results in a comprehensive and in-depth offender evaluation (e.g., personality, intelligence, psychopathy, developmental disabilities, etc.).
- III. If a pre-plea evaluation has been performed, once there is a finding of guilt, an offender evaluation that complies with the *Standards and Guidelines* shall be utilized to determine treatment needs.

¹¹ Amenability to domestic violence treatment refers to the offender’s capacity to effectively participate, function, and understand treatment concepts. Significant cognitive (e.g., thinking) impairments can preclude an individual’s ability to sufficiently pay attention during treatment sessions, learn new information, and/or self-reflect. Similarly, some cases of acute mental illness may interfere with participation due to the presence of impaired reality testing (e.g., delusions or hallucinations).

¹² Bonta, J., & Wormith, J. S. (2013). Applying the risk-need-responsivity principles to offender assessment. In L.A. Craig, L. Gannon, L., & T. A. Dixon (Eds.), *What works in offender rehabilitation: An evidence-based approach to assessment and treatment* (pp. 71-93). Hoboken, NJ: Wiley-Blackwell; Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., . . . Solano, I. (2016). Domestic Violence Perpetrator Programs: A Proposal for Evidence-Based Standards in the United States. *Partner Abuse*, 7(4), 355-460. doi:10.1891/1946-6560.7.4.355; Radatz, D. L., & Wright, E. M. (2016). Integrating the principles of effective intervention into Batterer Intervention Programming: The case for moving toward more evidence-based programming. *Trauma, Violence, & Abuse*, 17, 72-87. <http://dx.doi.org/10.1177/1524838014566695>.

- IV. Evaluations conducted for the purposes of pre-trial diversion that meet criteria set forth per § 18-1.3-101(5), C.R.S.¹³, shall conform to these *Standards and Guidelines* and be conducted by a Pre-Sentence Evaluator. Pre-Sentence Evaluators may make recommendations for treatment based on the results of an evaluation for consideration by the prosecuting agency.

Discussion Point: Approved Providers are sometimes referred clients whom have neither been charged or convicted of domestic violence in a criminal court, but are subject to court orders from a civil court. Pursuant to § 14-10-124(4)(IV)(f), C.R.S.¹⁴, if a finding of domestic violence is made, the offending party may be ordered to participate in a domestic violence offender evaluation and treatment as recommended. Civil orders for evaluations and treatment are not subject to the DVOMB Standards and Guidelines. Approved Providers may choose if and how they are to perform evaluations referred by civil court order and treatment to the participating party. The DVOMB encourages Approved Providers to use the DVOMB Standards and Guidelines as a best-practice guide in conjunction with their professional and ethical judgment appropriately.

4.04 Post-Sentence Offender Evaluation

- I. The post-sentence offender evaluation is a required component of the offender's intake process and shall be conducted with each offender by an Approved Provider. In cases in which a PSE has been completed and a copy has been obtained by the Approved Provider, the post-sentence offender evaluation shall expand upon the PSE as necessary and applicable (Reference "Required Minimum Sources of Information" Section 4.05). If there is a conflict between the pre- and post-sentence offender evaluation findings, the Approved Provider may consult with their Domestic Violence Clinical Supervisor (DVCS) or peer-consultant for resolution if needed.
- II. When the substance abuse screening and/or clinical judgment indicate the need for further assessment, the offender shall be referred to a CAC II, CAC III or LAC for a substance abuse assessment.
- III. When further offender mental health assessment is indicated and the Approved Provider is not a licensed mental health professional, the Approved Provider shall refer the offender to a licensed mental health professional for further assessment.

4.05 Required Minimum Sources of Information

To determine the most accurate prediction of risk, as well as offender treatment planning that comports with research and best practice, evaluations shall include sources of information, which include

¹³ In a jurisdiction that receives state moneys for the creation or operation of diversion programs pursuant to this section, an individual accused of an offense, the underlying factual basis of which involves domestic violence as defined in section 18-6-800.3 (1), is not eligible for pretrial diversion unless charges have been filed, the individual has had an opportunity to consult with counsel, and the individual has completed a domestic violence treatment evaluation, which includes the use of a domestic violence risk assessment instrument, conducted by a domestic violence treatment approved provider by the domestic violence offender management board as required by section 16-11.8-103 (4), C.R.S. The district attorney may agree to place the individual in the diversion program established by the district attorney pursuant to this section if he or she finds that, based on the results of that evaluation and the other factors in subsection (3) of this section, that the individual is appropriate for the program.

¹⁴ § 14-10-124(4)(IV)(f), C.R.S. When a civil court finds by a preponderance of the evidence that one of the parties has committed domestic violence, the court may order the party to submit to a domestic violence evaluation. If the court determines, based upon the results of the evaluation, that treatment is appropriate, the court may order the party to participate in domestic violence treatment. At any time, the court may require a subsequent evaluation to determine whether additional treatment is necessary. If the court awards parenting time to a party who has been ordered to participate in domestic violence treatment, the court may order the party to obtain a report from the treatment provider concerning the party's progress in treatment and addressing any ongoing safety concerns regarding the party's parenting time. The court may order the party who has committed domestic violence to pay the costs of the domestic violence evaluations and treatment.

integration of criminal justice information, victim input, other collateral information, previously performed offender evaluations, information obtained from a clinical interview of the offender, and the use of assessment instruments. Approved Providers shall comply with all mental health listing, licensure, or certification requirements regarding client confidentiality and privacy.

- I. Approve Providers shall obtain the following required sources of information:
 - A. Criminal justice and/or court documents including but not limited to the following:
 1. Law enforcement reports including the index offense report, affidavit or summary, and where available, the victim statements, other witness statements, and photos from current and prior incidents;
 2. Criminal history

Approved Providers shall attempt to obtain criminal justice and/or court documents first from the supervising officer (or agent). If this information is not provided by the supervising officer (or agent), then the Approved Provider may seek the information from the offender's legal representation (if available and at the discretion of counsel) or through the court, law enforcement, or prosecuting agency directly. Under no circumstances shall an Approved Provider request an offender to obtain the police report or victim statements.

- B. Victim input, including but not limited to victim impact statement (if available), written reports, direct victim contact, and information via a victim advocate or victim therapist. The MTT shall make victim safety and victim confidentiality its highest priority. Please refer to Section 7.05 for more information on victim information and confidentiality.

*Discussion Point: Women's perceptions of safety are substantial predictors of reassault.*¹⁵

- C. Any relevant and previously completed evaluations, treatment, and/or medical records. These may include, but are not limited to, offense-specific, psychological, psychiatric, substance abuse, or medical evaluations and records. If the Approved Provider is unable to obtain these records, the attempts made shall be documented.
 - D. Available collateral contacts directly related to the current offense (e.g., medical and mental health practitioners, Departments of Human Services)
 - E. Other collateral contacts as relevant and appropriate (e.g., family members)-
- II. Required Assessment Instruments

To provide the most accurate prediction of risk for domestic violence offenders, the offender evaluation shall include at a minimum, the use of instruments that have specific relevance to assessing domestic violence offenders. Assessment instruments used for the purpose of conducting an offender evaluation shall defer to the most current version and have demonstrated reliability and validity based on published research.

- A. Domestic Violence Risk Assessment Instruments¹⁶
 1. Domestic Violence Risk and Needs Assessment Instrument (DVRNA) (Reference *Standard*, 4.06 and Appendix G). This research-informed instrument is designed to assist in the classification of offenders based on risk and need to determine the appropriate intensity of treatment.
 2. At least one additional domestic violence risk assessment instrument.

¹⁵ Edward W. Gondolf, *Batterer Intervention Systems: Issues, Outcomes, and Recommendations*. (Thousand Oaks, CA: Sage Publications, 2001) 201.

¹⁶ Nicholls et al., (2013). Risk Assessment in Intimate Partner Violence: A Systematic Review of Contemporary Approaches, *Partner Abuse*, 4(1), 76-168.

- B. At least one substance abuse screening instrument¹⁷
- C. At least one mental health screening instrument
- D. At least one cognitive screening instrument.

III. Required Minimum Content of Offender Clinical Interview

The offender evaluation shall include a structured clinical interview¹⁸ with the offender and address the following evaluation areas as referenced in Appendix E:

- A. Psychosocial history
- B. Mental health history
- C. Substance use history
- D. Relationship history with attention to domestic violence dynamics and any issues related to power and control
- E. Prior history of trauma or adverse experiences
- F. Family history of sections B, C, D, and E above
- G. Criminogenic needs
- H. Offender accountability
 - I. Motivation for and amenability to treatment
- J. Responsivity factors

4.06 Domestic Violence Risk and Needs Assessment Instrument (DVRNA)

Placement in treatment shall be determined by the pre-sentence or post-sentence offender evaluation in conjunction with the Domestic Violence Risk and Needs Assessment Instrument (DVRNA) (Refer to annotated DVRNA). For any required form relating to the DVRNA, please refer to the DVRNA Scoring Manual (Appendix G).

I. Introduction

The literature demonstrates that there are significant risk factors that should be considered in working with domestic violence offenders. In the absence of a researched instrument that clearly identifies the ongoing risk of offenders during treatment; the following are some of the risk factors identified in the literature that shall be considered in treatment planning and ongoing Treatment Plan Review. These risk factors may not be present at the initial evaluation, but may become evident during treatment resulting in a need for a change in treatment planning and intensity of treatment. Additionally, mitigation of these risk factors may indicate a need for reduction in intensity of treatment. Once the offender has been evaluated according to Standard 4.0 Offender

¹⁷ Bruijn, D. & Graaf, I. (2016). The role of substance use in same-day intimate partner violence - A review of the literature, *Aggression and Violent Behavior* 27, 142–151.

¹⁸ R. Borum, "Improving the Clinical Practice of Violence Risk Assessment: Technology Guidelines and Training, *American Psychologists* 51:9 1996, 945-956.

Evaluation, the Approved Provider will complete the DVRNA. When identifying a risk factor for an offender, the Approved Provider is required to identify the source from which the information is drawn. This will help ensure that the information and risk determination is defensible. Examples of required sources include criminal history, law enforcement report, publicly released victim report/ impact statement, Office of Behavioral Health approved substance abuse screening instrument, offender clinical interview, mental health screen, and other information as required in Offender Evaluation Standard 4.05.

DVRNA was developed from several research studies that identify risk factors for future abuse or reoffense by known domestic violence offenders. The majority of this research was conducted on male offenders. Because there are some contextual differences between patterns of male and female offending, the MTT shall consider the relevance of these risk factors for females on a case by case basis.

II. Victim Information

- A. The ultimate goal in reviewing and utilizing victim information is to protect the victim.
 1. Information on confidential victim statements shall be kept in a file separate from the offender file.
 2. When a victim states that his/her information cannot be revealed beyond the Approved Provider, the Approved Provider and the victim advocate, without compromising victim confidentiality, may consult with probation and shall ascertain other potential ways to document or address victim concerns.

Example: If the victim reports substance abuse by the offender, the Approved Provider may require random urinalysis, thus obtaining information without revealing victim information.

III. Scoring Method Used in Determining Intensity of Treatment:

- A. Some risk factors on the DVRNA are identified as Critical or Significant and result in minimum placement for initial treatment. The actual placement level may be higher depending on the total number of domains in which there are risk factors.
- B. Offenders who do not have more than one risk factor as identified in the DVRNA may be considered for the Level A intensity of treatment. This one risk factor cannot be identified as Critical or Significant.
- C. The domains on the DVRNA are identified by letter (A-N). The risk factors listed under the domains are numbered. When scoring the DVRNA the maximum score for a domain is one. The maximum score on the DVRNA is therefore fourteen (14). Specific risk factors listed under the DVRNA do not each count for one point.
- D. Offenders who have two to four domains in which risk factors are present or any Significant Risk Factor as identified in the DVRNA, shall be placed in Level B intensity of treatment.
- E. Offenders who have five or more domains in which risk factors are present or any risk factor as identified as a Critical Risk Factor in the DVRNA shall be placed in Level C intensity of treatment.
- F. If the clinical and professional judgment of the MTT indicates a need to override the criteria listed above in A through D, there shall be consensus of the MTT and the written justification shall be placed in the offender's file.

IV. DVRNA Risk Factors

Risk factors are used as one measure to guide:

- Initial treatment planning including the design of offender competencies that must be demonstrated by the offender.
- Ongoing Treatment Plan Reviews that determine any or all of the following
 - Changes during treatment in regards to treatment planning,
 - Justification for changes to the Treatment Plan, such as required additional treatment or reduction in the intensity of treatment
 - Risk increase or mitigation

The following DVRNA domains of risk factors (A-N) shall be taken into consideration throughout an offender's treatment. Significant and Critical Risk Factors that warrant initial Level B or Level C placement are listed first for ease of use with this instrument.

Discussion Point: Please refer to the DVRNA Annotated Bibliography for further information regarding these individual risk factors.

- A. Prior domestic violence related incidents (Any of the following are Significant Risk Factors that indicate initial treatment placement in LEVEL B) (Ventura and Davis 2004; ODARA, 2005). This domain applies only to adult criminal history.
 1. Prior domestic violence conviction (ODARA, 2005) Critical Risk Factor that indicates initial treatment placement in Level C
 2. Violation of an order of protection (B-SAFER, 2005; Kropp & Hart, 2008; DVSI, 1998)
 3. Past or present civil domestic violence related protection orders against offender.
 4. Prior arrests for domestic violence (Ventura & Davis, 2004)
 5. Prior domestic violence incidents not reported to criminal justice system (Cattaneo & Goodman, 2003).
- B. Drug or alcohol abuse (Any of the following are Significant Risk Factors that indicate initial treatment placement in Level B at a minimum.). Requires use of a Division of Behavioral Health approved screening instrument(s) and/or self-report or recent illegal activity involving substance abuse to determine drug/alcohol abuse -- with emphasis on most recent 12 months.¹⁹
 1. Substance abuse/dependence within the past 12 months² (Kropp & Hart, 2008; B-SAFER, 2005; Weisz, et al., 2000; ODARA, 2005; Cattaneo & Goodman, 2003)
 2. History of substance abuse treatment within the past 12 months (Kropp & Hart, 2008; Klein, 2008) or two or more prior drug or alcohol treatment episodes during lifetime (DVSI, 1998)
 3. Offender uses illegal drugs or illegal use of drugs²⁰ (Campbell, 1995)

¹⁹ The Spousal Assault Risk Assessment (SARA) explains that substance misuse is related to criminality and recidivism in general, and recent substance misuse is associated with risk for violent recidivism among partner assaulters.

²⁰ Colorado Revised Statutes refers to "unlawful use of a controlled substance – using any controlled substance, except when it is dispensed by or under the direction of a person licensed or authorized by law to prescribe, administer, or dispense such controlled substance for bona fide medical needs."

- C. Mental health issue (Any of the following are Significant Risk Factors that indicate initial treatment placement in Level B at a minimum.)
1. Existing Axis I or II diagnosis (excluding Vcodes)
 2. Personality disorder with anger, impulsivity, or behavioral instability (Kropp & Hart, 2008; B-SAFER, 2005)
 3. Severe psychopathology (Gondolf, 2007; Hare 1998)
 4. Recent psychotic and/or manic symptoms (Kropp & Hart, 2008)
 5. Psychological/psychiatric condition currently unmanaged
 6. Noncompliance with prescribed medications and mental health treatment
 7. Exhibiting symptoms that indicate the need for a mental health evaluation
- D. Suicidal/homicidal
1. Serious²¹ homicidal or suicidal ideation/intent within the past year (Kropp & Hart, 2008) (This is a Critical Risk Factor that indicates initial treatment in Level C)
 2. Ideation within the past 12 months (Kropp & Hart, 2008; B-SAFER, 2005)
 3. Credible²² threats of death within the past 12 months (Kropp & Hart, 2008;)
 4. Victim reports offender has made threats of harming/killing her (female victims in heterosexual relationships²³ (Campbell, 2008)
- E. Use and/or threatened use of weapons in current or past offense (Kropp & Hart, 2008; Azrael & Hemenway, 2000) or access to firearms
1. Gun in the home in violation of a civil or criminal court order (Vigdor & Mercy, 2006) (This is a Critical Risk Factor that indicates initial treatment in Level C)
 2. Use and/or threatened use of weapons in current or past offense (Kropp & Hart, 2008; Azrael & Hemenway, 2000) (This is a Critical Risk Factor that indicates initial treatment in Level C)
 3. Access to firearms²⁴ (VPC, 2007; Paulozzi et al. 2001; Mitchell & Carbon, 2002; Mitchell & Carbon, 2002; Campbell, 2003; Saltzman, et al., 1992; Klein, 2008)
- Discussion Point: This is a containment issue that needs to be discussed by the MTT regarding community and victim safety.*
- F. Criminal history - nondomestic violence (both reported and unreported to criminal justice system). This domain applies only to adult criminal history.
1. Offender was on community supervision at the time of the offense (DVSI, 1998). (This is a Critical Risk Factor that indicates initial treatment in Level C.)
 2. Offender has a prior arrest for assault, harassment, or menacing
 3. (DVSI, 1998; Buzawa, et al., 2000; Ventura & Davis, 2004). If there have been two or more arrests²⁵, it is a Significant Risk Factor that indicates initial treatment in Level B at a minimum.
 4. Prior nondomestic violence convictions (DVSI, 1998; Klein, 2008; ODARA, 2005; Ventura & Davis, 2004)
 5. Past violation(s) of conditional release or community supervision (Kropp & Hart, 2008; B-SAFER, 2005; ODARA, 2005)

²¹ "Serious" as defined in the Spousal Assault Risk Assessment (SARA) means that the ideation is experienced as persistent and intrusive or involves high lethality methods; or that the level of intent is moderate to high.

²² "Credible" as defined in the Spousal Assault Risk Assessment (SARA) means that the threats were perceived as credible by the victim.

²³ Dr. Jacquelyn Campbell's work cited in this document refers to her work on femicide and only female victims in heterosexual relationships.

²⁴ Personal ownership of a firearm or living in a household with a firearm.

²⁵ The DVSI assigns one point for one prior arrest and two points for two or more prior arrests.

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6. Past assault of strangers, or acquaintances (Kropp & Hart, 2008; Weisz, et al., 2000; B-SAFER, 2005)
 7. Animal cruelty/abuse (Humane Society, 2007; Volant et al., 2008; Ascione, 1998; Faver & Strand, 2003, Ascione, 2007; Ascione, et al., 2007)
- G. Obsession with the victim:
1. Stalking or monitoring (Campbell, 2003; Block, Campbell, & Tolman, 2000)
 2. Obsessive jealousy with the potential for violence, violently and constantly jealous, morbid jealousy (Wilson & Daly, 1992; Hilberman & Munson 1978; Campbell, 2003)
- H. Safety concerns
(The ultimate goal in reviewing and utilizing information is to protect the victim. Information shall not be used if it compromises victim safety and confidentiality (Refer to *Standard 5.04 II.*).
1. Victim perception of safety/victim concerned for safety (Gondolf, 2001; Klein, 2008; Buzawa, et al., 2000; ODARA, 2005; Heckert & Gondolf, 2004)
 2. Victim (female victim in heterosexual relationship) believes offender is capable of killing her (Campbell, 1995).
 3. Offender controls most of victim's daily activities. (Campbell, 1995; Block, Campbell, & Tolman 2000; Tjaden & Thoennes, 2000)
 4. Offender tried to "choke"²⁶ victim (Campbell, 2008)
 5. Physical violence is increasing in severity (Kropp & Hart, 2008; B-SAFER, 2005)
 6. Victim forced to have sex when not wanted (Campbell, 1995)
 7. Victim was pregnant at the time of the offense and offender knew this (Martin et al., 2001; ODARA, 2005)
 8. Victim is pregnant and offender has previously abused her during pregnancy. (Gazmararian, 1996; Martin et al., 2001)

Discussion Point: The MTT may need to discuss any of the risk factors specific to a case to determine the most appropriate level of treatment based on victim safety and confidentiality. The utmost consideration must be given to confidentiality for victims.

- I. Violence and/or threatened violence²⁷ toward family members including child abuse (does not include intimate partners)
 1. Current or past social services case(s)
 2. Past assault of family members (Kropp & Hart, 2008)
 3. Children were present during the offense (in the vicinity) (DVSI, 1998)
- J. Attitudes that support or condone spousal assault²⁸ (Kropp & Hart, 2008; B-SAFER, 2005)
 1. Explicitly endorses attitudes that support or condone intimate partner assault.
 2. Appears to implicitly endorse attitudes that support or condone intimate partner assault.
- K. Prior completed or noncompleted domestic violence treatment (DVSI, 1998; Stalans et al., 2004)

²⁶ Although the medical terminology is "strangle", victims more readily identify with the word choke when reporting abuse.

²⁷ In the SARA #1 (Past Assault of Family Members), threatened assault of family members in the past.

²⁸ The SARA defines "spousal assault" as any actual, attempted, or threatened physical harm perpetrated by a man or woman against someone with whom he or she has, or has had, an intimate sexual relationship. This definition is not limited by the gender of the victim or perpetrator.

- L. Victim separated²⁹ from offender within the previous six months (DVSI, 1998; Campbell, et al., 2003)
- M. Unemployed (DVSI, 1998; Kyriacou, et al., 1999; Benson & Fox, 2004; B-SAFER, 2005) Unemployed is defined as not working at time of offense or at any time during intake or treatment and does not include offenders on public assistance, homemakers, students, or retirees
- N. Involvement with people who have pro-criminal influence.
 - 1. Some criminal acquaintances
The presence of some criminal acquaintances is associated with an opportunity for pro-criminal modeling, a concept that is considered a major risk factor (Andrews & Bonta, 2005).

AND

- 2. Some criminal friends
Attachments to pro-criminal others is a well-documented predictor of criminal behavior, with roots in both of the major explanatory theories in criminology: social control and social learning, (Andrews & Bonta, 2005).

4.07 Formulation of Treatment Recommendations, Alternative Options, and Considerations

- I. Formulations of Treatment Recommendations
 - A. The Approved Provider shall design an individualized treatment plan for the offender through conducting and completing the offender evaluation.
 - B. The recommendations from the offender evaluation shall be based upon a formulation of all pertinent data collected in the evaluation process. Each recommendation shall be clear, and concise with a supporting explanation. Treatment considerations should be based on the conclusions and recommendations of the offender evaluation.
 - C. Evaluation(s) shall result in an initial Offender Treatment Plan with the understanding that assessment is an ongoing process, which may necessitate changes to the plan through each transition of treatment and supervision process by the MTT.

Discussion Point: As a best practice, Approved Providers should complete the offender evaluation in no more than 30 days following the initial appointment and clinical interview. If the Approved Provider is unable to complete the offender evaluation within 30 days, the Approved Provider shall document the reasons why and communicate to the MTT.
 - D. Each individual treatment plan shall include at a minimum the recommended:
 - a. Initial level for placement in treatment based on the DVRNA (Reference Standard 4.06 for Levels of Treatment);³⁰

²⁹ The DVSI defines separation as the following: (1) Refers to physical separation (2) Separation may include going into shelter, moving out, moving in with friends or evicted the defendant.

³⁰ Coulter, M., & VandeWeerd, C. (2009). Reducing domestic violence and other criminal recidivism: Effectiveness of a multilevel batterers intervention program. *Violence and Victims*, 24(2), 139–152.

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- b. Treatment goals specific and measurable objectives to target criminogenic needs including, domestic violence and issues related to power and control;³¹
 - c. Methods for enhancing positive and pro-social factors;
 - d. Second contact interventions or treatment options that are the most clinically relevant to addressing the most significant criminogenic need for Level B and C offenders (not applicable for Level A offenders);
 - e. Supervision or monitoring recommendations needed to enhance the safety of the victim and offender containment;³²
 - f. Considerations for Specific Offender Population (as defined in *Standard 9.0*), Approved Providers shall utilize all applicable assessment criteria (Reference Appendix B).
- E. Approved Providers shall not recommend alternative therapies such as couples counseling, anger management or stress management in lieu of domestic violence offender treatment. Approved Providers shall not render legal opinions or recommendations. If a pre-plea evaluation has been performed, once there is a finding of guilt, an evaluation that complies with the *Standards and Guidelines* shall be utilized to determine treatment needs.
- F. The Approved Provider shall review the initial offender treatment plan with the MTT and accept input from the MTT. A treatment plan, with measurable goals, objectives, outcomes, and timeframes, shall be implemented after the completion of the offender evaluation process.

***Discussion Point:** The Approved Provider is a MTT member who is the subject matter expert regarding the treatment needs of the offender and who is responsible for providing services in accordance with DVOMB Standards and Guidelines. If the MTT has questions or concerns related to the offender's treatment plan, they should be addressed with the Approved Provider along with the other members of the MTT. The Approved Provider shall be the ultimate authority related to the treatment of the offender. The MTT should model pro-social, collaborative, and co-operative behavior for offenders when committed to the MTT model. This includes communicating clearly and effectively with each member of the MTT and with the offender.*

II. Considerations for the Assessment of Offenders when Domestic Violence Offender Treatment Is Contraindicated

Through the process of conducting and completing the offender evaluation, if indicators suggest that the offender's risk and criminogenic needs related to domestic violence and issues of power and control are not supported, the Approved Provider shall consider alternative treatment or intervention options. In such circumstances, the offender evaluation may recommend alternative interventions and treatment options. The offender evaluation shall include compelling clinical evidence that is well documented and using assessment instruments and collateral information when considering alternative interventions and possible treatment options.

***Discussion Point:** Should an Approved Provider determine that an offender is not amenable to domestic violence offender treatment under any of the following areas as prescribed by the Standards and Guidelines, the Approved Provider may request a variance from the Board for a modified domestic violence offender treatment plan in lieu of a recommendation for no domestic violence offender treatment.*

³¹ Radatz, D. L., & Wright, E. M. (2016). Integrating the principles of effective intervention into Batterer Intervention Programming: The case for moving toward more evidence-based programming. *Trauma, Violence, & Abuse, 17*, 72–87. <http://dx.doi.org/10.1177/1524838014566695>.

³² Webster, M. and K. Bechtel (2012). *Evidence-Based Practices for Assessing, Supervising and Treating Domestic Violence Offenders*. Crime and Justice Institute at Community Resources for Justice: Boston, MA.

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A. *Considerations for Assessing Self-Defending Victims when Domestic Violence Offender Treatment is Contraindicated*³³

If at any stage of the process (e.g. pre-sentence, post-sentence, or during treatment), the Approved Provider has clinical information (e.g., characteristics, context, and motivating factors) suggesting that the individual may be a self-defending victim, the following criteria, at a minimum, shall be considered to determine if domestic violence offender treatment per the *Standards* is contra-indicated:

- a. The individual acted out of fear, self-defense, and self-preservation in the current incident; OR
- b. The individual's behavior was situational and not used as a method of coercion, control, punishment, intimidation or revenge; OR
- c. The individual has suffered a pattern of domestic violence by their partner; OR
- d. The act or behavior was pre-emptively used to escape or to stop future abuse; OR
- e. The individual's criminal history did not involve threats to person(s), animal(s), or property.

If the Approved Provider recommends against domestic violence offender treatment, the MTT shall then be notified and consulted of the recommendation(s) to obtain consensus. The MTT will determine next steps. In such cases, the Approved Provider shall include in the offender evaluation a summary of supporting clinical documentation. The MTT may recommend alternatives for consideration by the presiding court or the Parole Board for possible modification to the sentencing order and requirements.

Discussion Point: Individuals who have been identified as self-defending victims have a right to safety and self-determination. Until the MTT reaches consensus, it is important for the MTT to consider all available options to minimize the risk of re-traumatizing the individual. These options include placing the individual on an administrative hold, conducting individual sessions, and gathering more clinical information for purposes of ongoing assessment. Approved Providers should practice within their clinical expertise and scope. Refer to Section 7.04(l) regarding guidance for TVAs on how to handle these types of situations.

B. *Considerations for Offenders Assessed as Having No Domestic Violence Offender Treatment Needs Based on the Absence of Risk and Criminogenic Needs*³⁴

1. Through the process of conducting the offender evaluation, if clinical indicators suggest that the offender does not present domestic violence and power and control dynamics related to domestic violence, then the Approved Provider shall consider alternative interventions and treatment options. When considering whether an offender has no domestic violence offender treatment need under the *DVOMB Standards and Guidelines*, the Approved Provider shall consider the following criteria using best clinical judgment:
 - a. The offender has been identified initially as requiring Level A treatment in addition to any other risk assessment instruments and collateral information indicating an absence of a criminogenic need for domestic violence offender treatment.
 - b. The offender does not have a history of engaging in coercion, threat, intimidation, revenge, retaliation, control, or punishment toward the victim in this case or in any other current or former relationships.

³³ Larance et al., (2019). Understanding and Addressing Women's Use of Force in Intimate Relationships: A Retrospective. *Violence Against Women*, 25(1) 56–80.

³⁴ Radatz, D. L., & Wright, E. M. (2016). Integrating the principles of effective intervention into Batterer Intervention Programming: The case for moving toward more evidence-based programming. *Trauma, Violence, & Abuse*, 17, 72–87. <http://dx.doi.org/10.1177/1524838014566695>.

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- c. The offender has little or no prior documented history of criminality or delinquency, excluding minor violations or violations posing no substantial threat to persons, animals or property. Consideration of the age of the offender at time of any identified prior offense, the circumstances of the offense, and whether there is a documented history of similar behavior may be considered.

Discussion Point: It is important to note that these cases arise in rare circumstances.

2. The Approved Provider shall consult with the MTT and obtain consensus when making a recommendation for an alternative intervention or treatment option. If there is a lack of conclusive clinical evidence in support of these criteria, the MTT may initially approve domestic violence offender treatment and reassess these considerations during the first Treatment Plan Review period to determine if domestic violence offender treatment is no longer needed or harmful.
3. At any stage of the process (e.g. pre-sentence, post-sentence, or at a treatment plan review), if an offender does not present with any domestic violence treatment needs nor any other general treatment needs, the Approved Provider may recommend that the offender should not be required to undergo any treatment based on the clinical judgement of the Approved Provider. In such cases, the Approved Provider shall consult with the MTT, obtain consensus, and may refer the case back to the presiding court or the Parole Board, according to local policy and procedure.

Discussion Point: In cases where the offender does not agree with the alternative treatment plan presented by the Approved Provider, the offender evaluation will be reviewed, modified as needed and finalized by consensus of the MTT. The finalized evaluation will include at minimum all the required elements as indicated in 4.03 and 4.04. According to local policy and procedure, a special report may be submitted to the court, the Parole Board, and/or a summons served upon the offender for hearing, for judicial consideration.

C. *Considerations for Assessing When a Significant Mental Health Disorder or Cognitive Impairment Contraindicates Domestic Violence Offender Treatment*

A domestic violence offender's amenability to engage in and benefit from domestic violence offender treatment may be impacted by the presence of a mental health disorder or cognitive impairment. It is critical for the Approved Provider to assess the extent to which an offender's mental health disorder or cognitive impairment and/or pervasive power and control dynamic are interrelated when making recommendations in the offender evaluation. As a result, the Approved Provider shall evaluate the offender to identify if and how the presence of any mental health disorders or cognitive impairment may impact the offender's amenability to successfully participate in domestic violence offender treatment and include diagnoses where appropriate and applicable.

If the Approved Provider does not have the appropriate expertise and credentials to diagnose, then the provider shall consult with a qualified mental health care provider or refer the offender to another provider who can make such a diagnosis.

1. If the Approved Provider determines that the offender is not amenable for domestic violence offender treatment due to a lack of stabilization of symptoms related to a mental health disorder, the Provider shall then identify what steps could be taken, if any, to assist the offender in being able to participate in domestic violence offender treatment.
2. If the Approved Provider determines that the offender is not amenable for domestic

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violence offender treatment due to a cognitive impairment that is beyond the capability of the therapeutic milieu to manage, the Approved Provider shall then identify what steps could be taken, if any, to assist the offender in being able to participate in domestic violence offender treatment.

3. For offenders whose mental health disorder or cognitive impairment is concurrent to a pathological power and control dynamic, adjunct mental health treatment may be conducted in conjunction with domestic violence offender treatment. Adjunct mental health treatment may be necessary to assist the offender in domestic violence offender treatment. In some cases, a referral to an adjunct mental health treatment or a health care provider may be prioritized prior to domestic violence offender treatment. This is done with MTT consensus in the interest of stabilizing the offender's needs.
 4. If the Approved Provider recommends against domestic violence offender treatment, the supervising officer (or agent) and Treatment Victim Advocate shall then be notified of the recommendation(s). The MTT will determine next steps. In such cases, the Approved Provider shall include in the offender evaluation a summary of supporting clinical documentation. The MTT may recommend alternatives for consideration by the presiding court or the Parole Board for possible modification to the sentencing order and requirements.
- D. *Considerations for Assessing Psychopathy³⁵ when Domestic Violence Offender Treatment is Contraindicated*

Domestic violence offenders who present with psychopathy may exhibit patterns of generalized violence and antisociality. An offender who is evaluated as psychopathic or as having significant psychopathic tendencies may be unmanageable in the community³⁶ and could present greater risk to victim(s) and the community at large (Refer to Appendix E).

Discussion Point: When possible, offenders whom present with characteristics that may be indicative of psychopathy should receive a PSE in order to allow for sentencing recommendations to be made to the presiding court.

1. An Approved Provider should use screening or assessment tools designed to identify psychopathy (e.g., PCL-R, PCL-SV, P-SCAN, MCMI-IV). These tools help determine if and how the offender can benefit from domestic violence offender treatment and their amenability to supervision in the community.
2. If the Approved Provider does not have the appropriate expertise and training to administer tools for identifying psychopathy, then the Approved Provider shall consult with a qualified mental health care provider or refer the offender to another provider who can perform the required testing to make a proper assessment.
3. At any stage of the process (e.g. pre-sentence, post-sentence, or during treatment), the Approved Provider may terminate services in the interest of victim and community safety, and make an alternative recommendation for needed intervention, if:

³⁵ Huss et al. (2006). Clinical Implications for the Assessment and Treatment of Antisocial and Psychopathic Domestic Violence, *Journal of Aggression, Maltreatment & Trauma*, Vol. 13(1), 59-85; Huss, M. & Langhinrichsen-Rohling, J., (2006). Assessing the Generalization of Psychopathy in a Clinical Sample of Domestic Violence Perpetrators. *Law of Human Behavior*, 30:571–586, DOI 10.1007/s10979-006-9052-x; Juodis et al., (2014). What Can be Done About High-Risk Perpetrators of Domestic Violence? *Journal of Family Violence*, 29:381–390, DOI 10.1007/s10896-014-9597-2.

³⁶ Unmanageable in the community can be evidenced by a history of repeated failures while under supervision by the criminal justice system.

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- (1) The Approved Provider makes a determination that domestic violence offender treatment is not appropriate due to clinical reasons related to the presence of psychopathy or significant psychopathic tendencies;

OR

- (2) The MTT makes a determination that the offender cannot be supervised adequately in the community under the current terms and conditions of supervision.

If a case meets the requirements of (1) or (2) above, the Approved Provider shall notify and carefully plan with members of the MTT for discharging the offender from domestic violence offender treatment (if applicable). The Approved Provider shall include in the offender evaluation a summary of supporting clinical documentation. In such cases, the domestic violence offender may be referred back to the presiding court or the Parole Board, according to local policy and procedure.

4.08 Required Minimum Reporting Elements for Submittal to the Multi-Disciplinary Treatment Team (MTT):

I. Offender Evaluation Summary

The purpose of the required written report to the supervising criminal justice agency (or agent) is to provide a summary of information obtained, assessed, and recommended from the offender evaluation. The report is intended to be brief and concise and to include, at a minimum, the following elements:

A. Identify Sources of Information

The written evaluation shall verify that all required sources of information were included. While victim input needs to be factored into the evaluation, no reference regarding victim contact or lack of contact shall be made in the report. The written evaluation shall not reveal specifics of how the victim input criteria was obtained or attribute victim input to a specific non-public record source. If the victim requests to have their input included in the written evaluation, written permission from the victim shall be obtained prior to any victim information being included in the evaluation summary and report. The evaluator has the discretion to omit victim statements if it endangers victim safety and/or compromises treatment goals.

A written release of information is not required for victim statements obtained from public records (e.g. police records). If victim statements are identified Approved Providers are required to specify that information came from a public record.

Discussion Point: While the expectation and intent is that all required information will be obtained, in the rare circumstance when a source of information could not be obtained, the Approved Provider shall document why that information could not be obtained, what efforts were made to obtain the information, and the resulting limitations of the evaluation and conclusions.

- B. Identify assessment instruments utilized such as assessment instruments, screening instruments, mental health, and/or substance abuse evaluation instruments
- C. Provide overview of the findings based at a minimum of the following areas:
 1. Domestic violence and issues of power and control

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2. Review of the DVRNA (Reference *Standard 5.04*) and one other domestic violence risk assessment instrument.
 3. Level and nature of domestic violence risk as described in terms of scenario development (e.g., likelihood, imminence, frequency, severity, victims, and context).³⁷
 4. Offender accountability (Reference Appendix E Section I)
 5. Offender motivation and prognosis (Reference Appendix E Section II)
 6. Criminogenic needs (Reference Appendix E Section IV)
 7. Offender responsivity (Reference Appendix E Section VI)
 8. Considerations and clinical factors unique to a Specific Offending Population (e.g., female offenders, LGBTQIA+ offenders) using the guidelines from Appendix B.
 9. Specific victim safety issues.
- D. Provide the initial treatment plan as required by Standard 4.07.

4.09 Ongoing Assessments and Updating Offender Evaluations

- I. Approved Providers shall conduct ongoing assessments of the offender’s compliance with, and progress in treatment. These assessments and Treatment Plan Reviews shall be performed at a minimum according to the *Standards* identified in Section 5.07 and when any potentially destabilizing change occurs in the offender’s life (e.g., job loss, divorce, or medical health crisis), or when any clinically relevant issues are uncovered (e.g., childhood trauma, prior relationship abuse, or re-emergence of mental health problems). The assessments may require the Approved Provider to modify the treatment plan and how the offender is being monitored in consultation with the MTT. The results of each assessment shall be added to the offender’s treatment plan and contract.
- II. When an offender transfers to a new Approved Provider or returns to treatment after an extended period of time, the Approved Provider shall attempt to obtain any previously completed pre- or post-sentence offender evaluations, treatment plan reviews, or discharge summaries. The prior offender evaluation may be amended for the purpose of updating assessment instruments and any clinically relevant findings. Considerations for when a prior offender evaluation is no longer valid and should be updated includes, but is not limited to, the following criteria:
 1. The prior offender evaluation was completed more than 60 days past the time of discharge;
 2. The offender committed a new offense while in treatment that suggests an increase in dynamic risk and poses a risk to the victim or community safety;
 3. The offender was discharged either administratively or unsuccessfully from domestic violence offender treatment.

³⁷ J. Reid Meloy and Thomas Schroder, Violence Risk and Threat Assessment: A Practical Guide for Mental Health and Criminal Justice Professionals (San Diego, CA: Specialized Training Services, 2000). Belfrage, H., & Strand, S. (2008). Structured spousal violence risk assessment: Combining risk factors and victim vulnerability factors. *International Journal of Forensic Mental Health*, 7(1), 39–46; Echeburúa, E., Fernández-Montalvo, J., de Corral, P., & López-Goñi, J. J. (2009). Assessing risk markers in intimate partner femicide and severe violence: A new assessment instrument. *Journal of Interpersonal Violence*, 24(6), 925–939.

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If the Approved Provider is unable to obtain these records, the attempts made shall be documented. If an Approved Provider updates an offender evaluation, the results of the updated evaluation shall formulate new treatment goals as appropriate.

***Discussion Point:** The decision to update or conduct a new offender evaluation should be based on factors regarding the recency of the prior offender evaluation, significance of the changes in the offender's life, and the emergence of new clinical information related to static and/or dynamic factors. Approved Providers are encouraged to consider these factors in conjunction with their overall clinical judgement of the individual offender and the potential victim and community safety concerns that may be present.*

- III. For offenders whom have previously attended domestic violence offender treatment, Approved Providers may assess the degree to which an offender comprehends and demonstrates the Core Competencies during the ongoing evaluation and treatment process. Approved Providers should exercise caution when assessing the extent to which an offender has met the Core Competencies when relying solely on offender self-report.

5.0 Offender Treatment

The purpose of treatment is to increase victim and community safety by reducing the offender’s risk of future abuse. Treatment provides the offender an opportunity for personal change. Treatment challenges destructive core beliefs and teaches positive nonviolent cognitive-behavioral skills. Although the degree of personal change ultimately rests with the offender, the MTT will monitor progress in treatment and hold the offender accountable for lack of progress.

Most professionals in the domestic violence field in Colorado agree that the time driven model (36 weeks) is historical, anecdotal, and not appropriate for all offenders. Professional consensus identified a need for differentiated treatment. General criminology research supports a differential treatment model determined by offender risk, criminogenic needs, and matching appropriate treatment intensity (Andrews & Bonta, 1994). These *Standards and Guidelines* incorporate different levels of treatment and focus on offender risk. The length of treatment in these revised *Standards and Guidelines* is determined by individual offender risk and progress in treatment (Refer to Overview Chart on page 39).

5.01 Basic Principles of Treatment

- I. **Provision of Treatment:** Treatment, evaluation, and assessment shall be provided by an Approved Provider at all times.
- II. **Victim Safety:** Victim safety shall be the priority of all offender treatment. Any treatment approach or practice that blames or intimidates the victim or places the victim in a position of danger is not appropriate. Ventilation techniques such as punching pillows, the use of batakas, etc., are not appropriate. Domestic violence offenders typically possess poor impulse control, and therefore, require intervention techniques that strengthen impulse control.
- III. **Intensity of Treatment:** Intensity of treatment shall be matched with offender risk. Levels of treatment will vary by intensity; such as low, moderate, or high intensity treatment. Intensity of treatment will vary by amount of offender contact during treatment; type of theoretical approach; and additional monitoring such as urinalysis, day reporting or monitored sobriety.

5.02 Multi-disciplinary Treatment Team (MTT)

- I. **MTT Membership:** The MTT consists of Approved Provider, responsible referring criminal justice agency, and Treatment Victim Advocate at a minimum. Other professionals relevant to a particular case may also be a part of the MTT such as human services, child welfare, and child protection services.

Discussion Point: Offenders who are sentenced to receive a domestic violence offender evaluation and treatment services are sometimes placed in the community without supervision (e.g., state probation, private probation, parole, or community corrections). Circumstances for unsupervised court orders vary, but these cases should be rare due to the possible risks posed to victim and community safety. The lack of a supervision officer can compromise the effectiveness of the MTT, offender containment, and accountability; can undermine efforts toward creating safe case management strategies; and may create ethical challenges for approved Domestic Violence Treatment Providers. Providers are encouraged to work with community stakeholders to address the lack of a supervising officer for domestic violence offenders when it occurs. This includes identifying strategies for how these offenders will be managed in such situations to enhance public safety. Domestic Violence Treatment Providers may accept such a client into treatment if, in their clinical judgment, it is in the best interests of the client, victim, and community safety to do so.

- II. MTT Purpose:** The MTT is designed to collaborate and coordinate offender treatment. Therefore, the work of the MTT needs to include staffing cases; sharing information; and making informed decisions related to risk assessment, treatment, behavioral monitoring, and management of offenders. The MTT by design may prevent offender triangulation and promote containment.
- III. MTT Training:** In the best interest of having an effective MTT, team members should successfully complete training specific to domestic violence in each of the following areas:
- Dynamics of domestic violence
 - Dynamics of domestic violence victims
 - Domestic violence risk assessment
 - Offender treatment

The MTT may also want to consider cross training to further develop team competency.

- IV. MTT Communication:** The MTT will determine the most effective methods and frequency of communication, which can include face to face and/or non-face to face contact. Information regarding frequency can be reviewed in the Treatment Plan Review Intervals in Standard 5.07.
- V. Offender Containment:** This is one of the goals of the MTT. The MTT will collaborate to establish consequences for offender noncompliance.
- VI. Victim Confidentiality:** The MTT shall make victim safety and victim confidentiality its highest priority. However, when the Treatment Victim Advocate makes contact with the victim, the victim shall be informed regarding the limits of confidentiality. The MTT has the responsibility to protect confidential information that cannot be discussed during the MTT process. Specific victim information may be shared with the MTT only after written consent has been given by the victim (Refer to *Standard 7.04g*). Therefore, the Treatment Victim Advocate will not be expected to violate victim confidentiality. In cases where there is not written consent or where the advocate has not had contact with the victim, the Treatment Victim Advocate provides perspectives and insights regarding victim issues in general, not regarding a specific victim. (Please note: Some information is not confidential such as homicidal, suicidal ideation/intent, and child abuse or neglect) Refer to *Standard 7.0* in its entirety.

Discussion Point: Protection of the victim is priority, therefore, if the only information available that would prevent offender discharge is victim information, and the MTT has determined that victim information cannot be revealed in order to protect the victim, and there are no other ways to validate or confirm, then the MTT may determine that discharge is appropriate.

MTT Consensus: Consensus is defined as the agreement among the team members. The MTT shall have consensus as its goal in managing offenders. The MTT shall reach consensus for the following phases of treatment, at a minimum: initial placement in treatment, when treatment planning indicates a change in level of offender treatment, and discharge. While there is acknowledgment that there is a supervising agent for the court, the intent and goal are to work collaboratively.

- A. MTT members are encouraged to discuss and attempt to resolve differences in order to achieve consensus. An effort should be made by MTT members to meet in person to work toward resolution.
- B. Potential conflict within the MTT: MTT members have the goal of settling conflicts and differences of opinion among themselves, which assists in presenting a unified response. The MTT is encouraged to review the Guiding Principles when resolving conflicts (Refer to Standard 3.0 in its entirety). MTT members may choose to justify in writing, utilizing offender competencies and risk factors for the court, the reason for their recommendations for treatment.
- C. If there is lack of consensus, each MTT member has the option of documenting his/her position and reasons for that recommendation.
- D. The MTT may request a meeting with the probation supervisor and/or Domestic Violence Clinical Supervisor if they believe it may help reach consensus, or
- E. In the rare event that there continues to be a lack of consensus, MTT members may document their recommendation and submit it to the court for ultimate decision. While the MTT is waiting for the decision of the court, all conditions of probation and treatment continue until a decision is made.

Discussion Point: The Approved Provider has the authority to discharge an offender from treatment. Probation has the authority to refer the offender to another Approved Provider or return the offender to court for further disposition.

VII. Treatment Report: At a minimum of once a month, the Approved Provider shall submit a written report to the supervising criminal justice agency to include:

- A. Results from most recent required Treatment Plan Review
- B. Offender progress regarding competencies
- C. Any recommendation related to discharge planning
- D. Offender's level of treatment

E. Evidence of new risk factors

F. Offender degree of compliance such as fees, attendance, and level of participation

5.03 Treatment Modality

I. Group Treatment: Group treatment (90 minute minimum) is the intervention of choice for domestic violence offenders. Approved Providers may decide whether groups will be open (accepting new offenders on an ongoing basis) or closed sessions. Groups shall not exceed 12 participants.

Discussion Point: The DVOMB believes that the treatment of domestic violence offenders is sufficiently complex and the likelihood of reoffense sufficiently high that the offender to therapist ratio and group size shall be limited.

II. Program Design: Primary Theoretical Approach: All Approved Providers shall design programs, which consist of psycho-educational and cognitive behavioral approaches as their primary intervention. Adjunctive approaches may be used, but never substituted for the primary approach.

III. Individual Treatment: Individual treatment (50 minute minimum) may be utilized on a case by case basis if the Approved Provider can demonstrate to the MTT an appropriate need for this treatment, such as crisis intervention, initial stabilization, or to address severe denial at the beginning of treatment. If individual treatment is the only form of treatment, it shall be for special circumstances. The Approved Provider shall document these special circumstances and the MTT consultation notes in the offender's case file.

IV. Gender Specific Group: All treatment groups and content shall be gender specific.

V. Sexual Orientation: All treatment groups shall be specific to sexual orientation and gender identity (Refer to Standard 10.08).

VI. Language: When possible, Approved Providers shall provide treatment in the offender's primary language or a secondary language in which the offender is fluent. If the Approved Provider is not fluent in the offender's primary or secondary language, the Approved Provider will, in conjunction with the MTT, refer the offender to a program that provides treatment in the offender's primary or secondary language. If no program exists, the Approved Provider shall, in collaboration with the referring criminal justice agency, refer the offender back to the court with a recommendation for an alternative disposition that is reasonably related to the rehabilitation of the offender and protection of the victim.

Discussion Point: It is also expected that the Approved Provider is also culturally competent with that population.

5.04 Development of Individualized Treatment Plan and Offender Contract

I. A Treatment Plan shall be implemented after the completion of the intake evaluation process. The individualized plan shall promote victim and community safety while identifying treatment goals for the offender. The written Treatment Plan shall include goals that specifically address all clinical issues identified in the intake evaluation. The treatment goals shall be based on offender criminogenic needs, offender competencies, and identified risk

factors. A Personal Change Plan and an Aftercare Plan shall be components of the Treatment Plan.

A. Personal Change Plan

The offender's Personal Change Plan is a written plan for preventing abusive behaviors and developing healthy thoughts and behaviors. The offender shall design and implement this plan during treatment and utilize it after discharge (Refer to Glossary).

B. Aftercare Plan

The offender's Aftercare Plan is a written plan that demonstrates the ongoing utilization of the Personal Change Plan after treatment and components supporting that plan (Refer to Glossary).

I. The Offender Contract is the signed treatment agreement between the Approved Provider and the offender that specifies the responsibilities and expectations of the offender, Approved Provider, and MTT.

A. Responsibilities of Offender: The Offender Contract shall include the following agreements by the offender:

1. To be free of all forms of "domestic violence" during the time in treatment (Refer to domestic violence in the Glossary).
2. To meet financial responsibilities for evaluation and treatment
3. To agree not to use alcohol or drugs; to agree not to use illegal drugs and not to use drugs illegally. This includes misuse or abuse of prescribed medications. If substance abuse treatment is indicated, offender shall complete the substance abuse treatment and abide by any conditions that may be applied as determined by the substance abuse evaluation.
4. To sign releases of information allowing the Approved Provider to share information as required by Standard 10.08.
5. To not to violate criminal statutes or ordinances (city, county, state, or federal)
6. To comply with existing court orders regarding family support
7. To comply with any existing court orders concerning a proceeding to determine paternity, custody, the allocation of decision making responsibility, parenting time, or support.
8. To not purchase or possess firearms or ammunition
An exception may be made if there is a specific court order expressly allowing the offender to possess firearms and ammunition. In these cases, it is incumbent upon the offender to provide a copy of the court order to the Approved Provider to qualify for this modification of the Offender Contract. It is then incumbent upon the Approved Provider to design treatment planning to address storage of the firearm, (such as firearm shall not be allowed in the home) and other factors related to offender risk, safety planning, and victim safety.
9. To not participate in any couple's counseling or family counseling while in offender treatment. This includes any joint counseling that involves the offender and the victim.

B. Responsibilities of Approved Provider: The Offender Contract shall include the following disclosures by the Approved Provider:

1. Offenders who have committed domestic violence related offenses shall waive confidentiality for purposes of evaluation, treatment, supervision, and case management. The offender shall be fully informed of alternative disposition that may occur in the absence of consent/assent (Refer to Standard 6.0 in its entirety).

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Offender waivers of confidentiality shall also extend to the victim, specifically with regard to (1) the offender's compliance with treatment and (2) information about risk, threats, and/or possible escalation of violence

2. Costs of evaluation and treatment services
3. Grievance procedures should the offender have concerns regarding the Approved Provider or the treatment
4. Response plan for offenders in crisis
5. Intensity of treatment
6. Information on referral services for 24-hour emergency calls and walk-ins
7. Reasons that the offender would be terminated from treatment
8. Disclosure that the Approved Provider and his/her records may be audited by the DVOMB for the new application process and Biennial Renewal.
9. Offender fees: The offender paying for his/her own evaluation and treatment is an indicator of responsibility and shall be incorporated in the treatment plan. All Approved Providers shall offer domestic violence offender evaluation and treatment services based on a sliding fee scale (Refer to Glossary).

C. Offender Absences

1. Offenders are responsible for attending treatment.
2. If an offender has more than three absences, the MTT shall consult to determine any needed consequences or modifications to the Treatment Plan. The MTT may require the offender to provide documentation of reasons for absences.
3. All offender absences shall be reported within 24 hours of the absence to the Treatment Victim Advocate and the referring agency. The Treatment Victim Advocate will determine if the victim shall be notified according to the agreement with the victim (Refer to Standard 7.0 in its entirety). The referring agency may request a modification of the notification criteria.

D. Violations of Offender Contract

Violations of Offender Contract or noncompliance with the Treatment Plan may lead to termination from the program. At a minimum, written or verbal notification of the violations shall be provided to the MTT. Notification of the violations on noncompliance will be provided to law enforcement and/or courts, when appropriate. Violations of the Offender Contract may include exhibiting signs of imminent danger to others or escalating behaviors that may lead to violence.

5.05 Levels of Treatment

I. There are three levels of treatment that include Level A (low intensity), Level B (moderate intensity), and Level C (high intensity). Offenders are placed in a level of treatment based on the findings from the intake evaluation, offender treatment needs, and level of risk as identified by the DVRNA. Research demonstrates that matching offender risk to intensity of treatment reduces recidivism (Andrews & Bonta, 1994). Intensity of treatment is differentiated by frequency of clinical contact and content of treatment.¹

II. Initial Determination of Treatment Level is recommended by the Approved Provider after the Offender Intake Evaluation has been completed and approved by the MTT. While some offenders may remain in the same level throughout treatment, there is also the ability to move offenders to a different level of treatment as needed. This is based on new information such as change in risk factors, mitigation of risk, continuing abuse, or denial.

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- A. Only offenders in Level C may be considered for a decrease in treatment level and then only to Level B.
- B. No offenders in Level B or C are eligible for a decrease in treatment to Level A.
- C. Decreasing an offender's level of intensity of treatment shall only occur at scheduled Treatment Plan Review intervals and shall be approved by consensus of the MTT. This change in treatment level shall include written justification placed in the offender's file describing the need for change in treatment.
- D. Increasing an offender's level of treatment to a higher intensity of treatment may occur at any time and shall be approved by consensus of the MTT. This change in treatment level shall include written justification placed in the offender's file describing the need for change in treatment.

III. If any Information is Missing from the Offender Intake Evaluation and the DVRNA, an offender shall not be placed in Level A. A Temporary Placement to treatment Level B may be indicated. Because the missing information may be related to risk factors, there is a need for safety considerations, resulting in a minimum Temporary Placement to Level B. Even though there is information missing, there may be sufficient information obtained from the DVRNA to justify the offender's placement in Level C.

- A. Of the missing information, the MTT will identify that which is unobtainable and document why. However, if the missing information is a result of lack of offender cooperation, the MTT shall take this into account in its determination of level of treatment. Offender resistance or noncompliance (e.g. release of information) shall result in ineligibility for placement in Level A.

Once missing information has been received, the MTT shall determine the appropriate level of treatment, which may be Level A, B, or C. If the Temporary Placement was to Level B, and after reviewing additional information, the MTT determines treatment shall be Level A, it is not considered a decrease in treatment intensity.

- B. The MTT shall make a determination within 30 days of the offender intake evaluation.

IV. Parameters for Treatment Levels

- A. When an offender is in severe denial (Refer to Glossary), the MTT shall consider individual sessions or a group format to address the denial.

Discussion point: Placing an offender with severe denial in group with offenders who are not exhibiting severe denial may not be appropriate for the offender or the group.

- B. Groups shall differ based on function; such as educationally focused or a combination of education and therapy, or skills based group. Approved Providers are not required to create three distinctly different groups but may create a combination of modalities.
- C. The first principle for differentiating treatment, repeatedly found to be valid in criminal justice interventions, is that higher and lower risk offenders shall not be treated together (Lowencamp & Latessa, 2004). Therefore, Level A and C shall not be together for therapeutic sessions.

¹ Refer to chart on page 5-33 entitled "Overview Chart of 5.0 Offender Treatment"

- D. Offenders in all levels of treatment may be together for some educational non-therapeutic classes.
- E. Some offenders in Level C treatment who exhibit features of psychopathy may not be appropriate for empathy based treatment (Hare, 1993; Hare, 1998).

V. Safeguards

Certain safeguards have been created to ensure that offenders are monitored and that victim safety is the highest priority. These safeguards include the following:

- A. Victim information shall be protected and victim confidentiality maintained at all times.
- B. All offenders shall have at least the minimum number of required Treatment Plan Reviews at identified intervals based on level of treatment and individual Treatment Plan(s).
- C. Prior to the first required Treatment Plan Review, the Approved Provider shall have obtained and reviewed offender criminal history and available victim contact information.
- D. Core competencies shall be demonstrated by offenders prior to discharge (Refer to *Standard 5.08*).
- E. Offender risk factors shall be addressed by offender competencies. Some offenders will have additional risk factors that require demonstration of additional competencies and additional Treatment Plan Reviews.
- F. Offender risk is dynamic and may increase during treatment resulting in the need for additional offender competencies being added to the Treatment Plan.
- G. If the offender is deemed to be a risk to the community, an alternative disposition shall be discussed with the MTT and subsequently recommended to probation.

VI. Level A (Low Intensity)

The offender population that is identified for Level A at the initial placement in treatment does not have an identified pattern of ongoing abusive behaviors. They have a pro-social support system, may have some established core competencies, minimal criminal history, and no evidence at the beginning of treatment of substance abuse or mental health instability.

- A. Placement Criteria for Level A
 1. MTT consensus
 2. Offenders are not appropriate for Level A if there is still missing information from the intake evaluation or the Domestic Violence Risk and Needs Assessment instrument (DVRNA). The responsibility to obtain information may rest with the MTT or the offender.
 3. If one or no risk factors are identified from the implementation of the DVRNA and the pre or post-sentence intake evaluation (Refer to *Standard 4.0* in its entirety), there is a need for low intensity treatment.
 4. Offenders who are placed in Level B or C are never eligible to be moved to Level A.

Discussion Point: The MTT should take into consideration victim safety concerns before placing an offender into Level A. Because this level of treatment for an offender is low intensity and potentially a shorter period of time, victim safety must

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continue to be monitored where possible and appropriate. Some victims may be
reluctant to provide information regarding the offender at the point of initial
evaluation or early in treatment and more information may become available as
treatment continues.*

B. Intensity of Treatment

1. Content and Contact

- a. Group clinical sessions that address psycho-educational content, core competencies, criminogenic needs, and Treatment Plan issues.
- b. Clinical sessions shall be held once a week

C. Transition

If new disclosure/information is obtained and risk factors increase, offender shall be moved to Level B or Level C.

VII. Level B (Moderate Intensity)

The offender population that is identified for Level B treatment has moderate risk factors. At the initial placement of treatment, they have an identified pattern of ongoing abusive behaviors. There may also be some denial of the abuse and some moderate resistance to treatment. They may or may not have a pro-social support system and may have some criminal history. There may be some evidence at the beginning of treatment of moderate substance abuse or mental health issues. Therefore, the following is identified as the most appropriate intensity of treatment for this population.

A. Placement Criteria for Level B

1. MTT consensus
2. Two to four risk factors identified in the DVRNA or one Significant Risk Factor identified in the DVRNA that indicates initial placement in Level B. Additionally, the pre- or post-sentence intake evaluation (Refer to Standard 4.0 in its entirety) identifies a need for moderate intensity of treatment.
3. Additional risk factors identified by the MTT for an offender in Level A justify a placement in Level B.
4. If risk factors are mitigated for an offender in Level C, the offender may be moved to Level B if there is MTT consensus.

B. Intensity of Treatment

1. Content and Contact: Weekly group clinical sessions that address core competencies, criminogenic needs, and Treatment Plan issues using cognitive behavioral treatment plus at least one additional monthly clinical intervention from the following list:
 - a. An individual session to address denial or resistance
 - b. A clinical contact to further evaluate and/or monitor issues such as mental health
 - c. Additional treatment such as substance abuse treatment or mental health treatment

Substance abuse treatment: Violence cannot be successfully treated without treating substance abuse problems. All offenders evaluated as needing substance abuse treatment shall complete such treatment. Such treatment shall be provided by a CAC II or higher. If the Approved Provider does not provide a substance abuse treatment program, the Provider shall conduct shared case supervision and treatment planning with the counselor providing the substance abuse treatment at a minimum of once per month or more frequently as the case dictates.

C. Transition

If new disclosure/information is obtained and risk factors increase, offender shall be moved to Level C. Offenders at this level are never eligible to move to Level A.

VIII. Level C (High Intensity)

The offender population that is identified for Level C treatment has multiple risk factors. These individuals will most likely require cognitive skills based program. There may be significant denial and high resistance to treatment. These individuals often have employment and/or financial instability. In general they do not have a pro-social support system. They are likely to have a criminal history and substance abuse and/or mental health issues. Therefore, stabilization of the offender and crisis management may be needed at the beginning of treatment.

A. Placement Criteria for Level C

1. MTT consensus
2. Five or more risk factors identified in the DVRNA or one Critical Risk Factor identified in the DVRNA that indicate initial placement in Level C Additionally, the pre- or post-sentence intake evaluation (Refer to Standard 4.0 in its entirety) identifies a need for a high intensity treatment.
3. Additional risk factors are identified by the MTT for an offender in Level A that justifies a placement in Level C.
4. Additional risk factors are identified by the MTT for an offender in Level B that justifies a placement in Level C.

B. Intensity of Treatment

1. Content and Contact: Minimum of two contacts per week. One contact to address core competencies and one treatment session such as cognitive skills group, substance abuse, or mental health issues group.
 - a. A clinical contact involves therapeutic intervention specifically related to the offender's criminogenic needs and risk factors. Therefore the two contacts cannot be on the same day.
 - b. The intent of this level of treatment is to disrupt patterns of abuse.
 - c. Face to face contact is required so the Approved Provider can assess the offender's attention level responsiveness, appearance, possible substance abuse, and mental health status. This contact will also assess and promote victim safety.
2. Substance abuse treatment: Violence cannot be successfully treated without treating substance abuse problems. All offenders evaluated as needing substance abuse treatment shall complete such treatment. Such treatment shall be provided by a CAC II or higher. If the Approved Provider does not provide a substance abuse treatment program, the Approved Provider shall conduct shared case supervision (treatment planning) with the Approved Provider providing substance abuse treatment at a minimum of once per month or more frequently as the case dictates.

C. Transition

If the offender progresses in treatment and if risk factors are mitigated, the MTT may reduce the offender intensity of treatment to Level B. Offenders in Level C are never eligible to move to Level A.

5.06 Required Treatment Plan Review Intervals For All Levels

The purpose of the Treatment Plan Review is to re-assess offender degree of progress and risk, and to make any necessary modifications to the Treatment Plan and goals. The intensity of treatment may need to be modified based on the findings of the Treatment Plan Review.

I. The Approved Provider shall review the Treatment Plan and the offender's progress toward meeting treatment goals. The Approved Provider shall consult with members of the MTT at all Treatment Plan Review intervals and shall provide feedback to the MTT regarding the outcome. The Approved Provider shall review the offender's Treatment Plan with the offender. At the conclusion of each Treatment Plan Review, the next Treatment Plan Review will be scheduled and noted in the Treatment Plan. The offender shall sign the Treatment Plan to acknowledge the review.

Discussion Point: The Treatment Plan Review may be done in lieu of, or in addition to, the regularly scheduled monthly Treatment Report.

II. Treatment Plan Review shall include at a minimum:

- A. Input from probation, such as compliance with probation terms and conditions, and new criminal history

Discussion Point: If there is no probation supervision, use Colorado Bureau of Investigation's website or contact the judge if appropriate.

- B. Input from Treatment Victim Advocate, even if victim contact in a given case is unavailable
- C. Review of offender progress in accordance with the Treatment Plan, offender competencies, and risk factors.
- D. MTT verification that no additional risk factors have been identified or reported through other sources outside of offender contact as relevant (e.g. social services, psychiatrist, new partner, parents, or clergy)

Discussion Point: This list of suggested contacts is intended to be a guideline regarding who to contact. The MTT can determine who is appropriate or relevant to contact on a case by case basis throughout treatment as well as prior to discharge.

III. Approved Providers shall complete the first Treatment Plan Review after the completion of two to three months of treatment. This first Treatment Plan Review shall be scheduled and identified in the offender's initial Treatment Plan.

- A. Purpose of this Treatment Plan Review is to reevaluate whether the offender is in the appropriate level of treatment, refine the Treatment Plan in accordance with the next Treatment Plan Review period, and to measure progress. Offenders are not eligible for discharge at the first Treatment Plan Review period. The Treatment Plan Review shall include a review of the offender's understanding and application of competencies.

- B. Any missing information from the DVRNA or offender intake evaluation shall be obtained, reviewed, and incorporated into treatment planning. If the information was the offender's responsibility to obtain, the Approved Provider shall consult with the MTT and determine how to proceed regarding the missing information and the offender's lack of compliance.

IV. The Second required Treatment Plan Review shall occur two to three months after the completion of the first Treatment Plan Review.

- A. Purpose of this Treatment Plan Review is to measure offender progress and motivation, and to determine whether there are additional clinical needs necessary to achieve treatment goals and to determine whether additional Treatment Plan Reviews are needed.
- B. The MTT shall determine whether additional treatment plan reviews are needed based on the offender's progress toward meeting treatment goals and offender competencies. If the offender has not met all treatment goals nor met all discharge criteria, then additional Treatment Plan Reviews shall be scheduled. The offender shall be informed of the goals for the next Treatment Plan Review and the goals shall be identified in writing.
- C. Treatment Discharge planning may begin for Level A offenders at this Treatment Plan Review only if offenders can complete all required Treatment Completion Discharge criteria prior to the next Treatment Plan Review (Refer to *Standard 5.09 I*). Once the discharge criteria have been met, the MTT may determine the discharge date. Treatment Discharge is based on an offender demonstrating and understanding of all required competencies, completion of treatment goals, mitigation of risk, and other factors as identified in the Treatment Plan.

V. Additional or subsequent Treatment Plan Reviews shall be performed as determined by the MTT and shall be done at intervals of two to three months.

- A. Offenders placed in Levels B and C shall have at least one additional Treatment Plan Review. The purpose of the Treatment Plan Review is to measure offender progress and motivation, and to determine whether there are additional clinical needs to achieve treatment goals and to determine whether additional Treatment Plan Reviews are needed.
- B. The MTT shall determine whether additional treatment plan reviews are needed based on the offender's progress toward meeting treatment goals and offender competencies. If the offender has not met all treatment goals nor met all discharge criteria, then additional Treatment Plan Reviews shall be scheduled. The offender shall be informed of the goals for the next Treatment Plan Review and the goals shall be identified in writing.
- C. Treatment discharge planning may begin for Level B and C offenders at this Treatment Plan Review only if all treatment goals and 5.09 I Offender Discharge Treatment Completion criteria have been met or can be met prior to the next Treatment Plan Review. Treatment Discharge is based on an offender demonstrating an understanding and application of all required competencies, completion of treatment goals, mitigation of risk, and other factors as identified in the Treatment Plan (Refer to *Standard 5.09 I*). Once the discharge criteria have been met, the MTT may determine the discharge date.

VI. A Treatment Plan Review may need to be performed at any time as justified by such factors as a crisis situation for the offender, discovery of new risk factors, new arrest, etc. This Treatment Plan Review would be in addition to the required Treatment Plan Reviews.

VII. Options for offenders in Level A and B Treatment after Treatment Plan Review is performed:

- A. Continue the offender's Treatment Plan as designed and review progress, stagnation, or regression with offender, including scheduling additional Treatment Plan Reviews as needed. (Refer to *Standard 5.07 V B*). Completion of a Treatment Plan Review does not require conducting an individual counseling session with the offender.
- B. Increase intensity of the offender's current level of treatment, or increase the level of treatment based on lack of offender progress demonstrated by using offender competencies, identification of additional risk factors, or input from any MTT member.

VIII. Options for offenders in Level C Treatment after Treatment Plan Review is performed:

- A. Continue the offender's Treatment Plan as designed and review progress, stagnation, or regression with offender, including scheduling additional Treatment Plan Reviews as needed (Refer to Section 5.07 V B). Completion of a Treatment Plan Review does not require conducting an individual counseling session with the offender.
- B. Increase intensity of Level C treatment based on lack of offender progress demonstrated by using offender competencies, identification of additional risk factors, or input from any MTT member.
- C. Decrease level of treatment based on offender progress demonstrated by using offender competencies, reducing or mitigating risk, or reviewing reports from probation or the Treatment Victim Advocate. (Shall have consensus of the MTT.)

5.07 Offender Competencies

I. Purpose and use of Offender competencies

- A. Develop Offender Contract and Treatment Plan
- B. Monitor offender behavioral change
- C. Re-evaluate offender during Treatment Plan Reviews throughout treatment
- D. Verify discharge criteria

II. Offender Responsibility¹ (Bancroft & Silverman, 2002)

All offenders shall be required to demonstrate an understanding and application of the core competencies to the Approved Provider and the MTT, as determined by the Treatment Plan. Offenders placed in Level B or Level C treatment shall be required to demonstrate additional competencies as determined by the MTT.

¹ Portions of the offender competencies were obtained and adapted from Colorado Adult Sex Offender Standards

III. Approved Provider Responsibility

Approved Providers have the responsibility to provide the opportunity for offenders to learn and demonstrate these competencies as well as to evaluate, verify, and document the presence and demonstration of competencies.

Approved Providers as a member of the MTT shall consult with the supervising criminal justice agency, Treatment Victim Advocate, and other agencies involved with an offender throughout treatment to assess, as a team, the offender degree of demonstration and understanding of the competencies.

IV. MTT Responsibility

The MTT shall always have victim safety and confidentiality as the priority of offender treatment and assessment. The MTT shall assess and determine the degree to which all of the offender competencies are met and determine the treatment status, and when appropriate, discharge accordingly.

The MTT shall assess offender progress and demonstration of offender competencies by utilizing a variety of sources of information. The ultimate goal in reviewing and utilizing information is to protect the victim. Information shall not be used if it compromises victim safety and confidentiality. Therefore, when a victim states that information cannot be revealed, the MTT shall seek and utilize other sources of information such as degree of offender participation in group, urine analysis, and contact with probation (Refer to *Standard 7.0* in its entirety).

V. Core Competencies:

The offender shall actively participate in treatment. Participation means demonstrating that the offender understands and applies the following core competencies in one's life. This behavior is observable by others and consistent with ongoing Treatment Plan Review.

Core competencies are required and can be demonstrated by, but not limited to, completing homework assignments, journaling, role playing, and actively participating in group; by applying what he/she is learning in treatment (Bancroft & Silverman, 2002). These competencies are not set forth as a linear curriculum order or as a prioritized list of behavioral goals. They represent the final goals of treatment to be measured at Treatment Plan Reviews.

The Approved Provider shall determine the implementation order of core competencies (items A through R). The numbered items are suggested ways to demonstrate the competencies, but all numbered items are not required. Some offenders may need a more expanded version of these core competencies.

- A. Offender commits to the elimination of abusive behavior
 - 1. Eliminates the use of physical intimidation, psychological cruelty, or coercion toward one's partner or children.
 - 2. Begins developing a comprehensive Personal Change Plan that is approved by the MTT and signed by the offender (Refer to Glossary for definition of Personal Change Plan).

- B. Offender demonstrates change by working on the comprehensive Personal Change Plan
 - 1. Begins implementing portions of the Personal Change Plan.

2. Accepts that working on abuse related issues and monitoring them is an ongoing process.
 3. Begins designing an Aftercare Plan (Refer to Glossary).
 4. Completes an Aftercare Plan and is prepared to implement this plan after discharge from treatment.
- C. Offender completes a comprehensive Personal Change Plan
1. Reflects the level of treatment and has been reviewed and approved by the MTT.
 2. Driven by the offender's risk and level of treatment (required for all levels but must be more specific and detailed for Level B and C treatment).
- D. Offender development of empathy
1. Recognizes and verbalizes the effects of one's actions on one's partner/victim.
 2. Recognizes and verbalizes the effects on children and other secondary and tertiary victims such as neighbors, family, friends, and professionals.
 3. Offers helpful, compassionate response to others without turning attention back on self.

***Discussion Point:** Some offenders may have significant deficits related to empathy due to such issues as psychopathy, antisocial features, developmental or learning disabilities, and/or psychological impairments. As a result, Approved Providers in conjunction with MTT may assess the offender's capacity for empathy and plan adjunctive treatment accordingly. Additionally, in some cases it is contraindicated to address offender empathy. These offenders shall not be participating in empathy-based treatment (Hare, 1998).*

- E. Offender accepts full responsibility for the offense and abusive history (Bancroft & Silverman, 2002)
1. Discloses the history of physical and psychological abuse towards the offender's victim(s) and children.
 2. Overcomes the denial and minimization that accompany abusive behavior. In the event the offender exhibits severe denial, refer to Standard 5.06 IV A and the Glossary.
 3. Makes increasing disclosures over time.
 4. Accepts responsibility for the impact of one's abusive behavior on secondary, tertiary victims, and the community.

***Discussion Point:** Collateral information such as the police report may be utilized to expand the offender's perspective of other's perceptions of the offense.*

5. Recognizes that abusive behavior is unacceptable. The offender has agreed that the abusive behavior is wrong and will not be repeated. This involves relinquishing excuses and any other justifications that blame the victim; including the claim that the victim provoked the offender.
- F. Offender identifies and progressively reduces pattern of power and control behaviors, beliefs, and attitudes of entitlement.
1. Recognizes that the violence was made possible by a larger context of the offender's behaviors and attitudes (Pence & Paymar, 1993)

2. Identifies the specific forms of day-to-day abuse and control, such as isolation that have been utilized, as well as the underlying outlook and excuses that drove those behaviors (Bancroft & Silverman, 2002).
3. Demonstrate behaviors, attitudes and beliefs congruent with equality and respect in personal relationships.

G. Offender Accountability (Refer to 4.0 Appendix)

Offender accountability is defined as accepting responsibility for one's abusive behaviors, including accepting the consequences of those behaviors, actively working to repair the harm, and preventing future abusive behavior.

Accountability goes beyond taking ownership; it is taking corrective actions to foster safety and health for the victim. The offender demonstrates behavioral changes to alleviate the impact of offender's abusive words and/or actions regardless of the influence of anyone else's words or actions (Refer to 4.0 Appendix).

1. Recognizes and eliminates all minimizations of abusive behavior. Without prompts, the offender identifies one's own abusive behaviors.
2. Demonstrates full ownership for his/her actions and accepts the consequences of these actions (Bancroft & Silverman, 2002). The offender demonstrates an understanding of patterns for past abusive actions and acknowledges the need to plan for future self-management and further agrees to create the structure that makes accountability possible (Pence & Paymar, 1993).
3. "They accept that their partner or former partner and their children may continue to challenge them regarding past or current behaviors. Should they behave abusively in the future, they consider it their responsibility to report those behaviors honestly to their friends and relatives, to their probation officer, and to others who will hold them accountable." (Bancroft and Silverman, 2002)

H. Offender acceptance that one's behavior has, and should have, consequences (Sonkin, et al., 1985; Bancroft & Silverman, 2002).

1. Identifies the consequences of one's own behavior and challenges distorted thinking and understands that consequences are a result of one's actions or choices. The offender makes decisions based on recognition of potential consequences.
2. Recognizes that the abusive behavior was a choice, intentional and goal-oriented (Pence & Paymar, 1993). For example, the offender has stopped using excuses such as being out of control, drunk, abused as a child, or under stress.

I. Offender participation and cooperation in treatment

1. Participates openly in treatment (e.g. processing personal feelings, providing constructive feedback, identifying one's own abusive patterns, completing homework assignments, presenting letter of accountability).
2. Demonstrates responsibility by attending treatment as required by the Treatment Plan.

J. Offender ability to define types of domestic violence

1. Defines coercion, controlling behavior and all types of domestic violence (e.g. psychological, emotional, sexual, physical, animal abuse, property, financial, isolation).
2. Identifies in detail the specific types of domestic violence engaged in, and the destructive impact of that behavior on the offender's partner and children (Pence & Paymar, 1993; SAFE JeffCo., 2002).

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3. Demonstrates cognitive understanding of the types of domestic violence as evidenced by giving examples and accurately label situations (SAFE JeffCo, 2002).
 4. Defines continuum of behavior from healthy to abusive.
- K. Offender understanding, identification, and management of one's personal pattern of violence.
1. Acknowledges past/present violent/controlling/abusive behavior
 2. Explores motivations
 3. Understands learned pattern of violence and can explain it to others
 4. Disrupts pattern of violence prior to occurrence of behavior
- L. Offender understanding of intergenerational effects of violence
1. Identifies and recognizes past victimization, its origin, its type and impact
 2. Recognizes the impact of witnessed violence
 3. Acknowledges that one's upbringing has influenced current behaviors
 4. Develops and implements a plan to distance oneself from violent traditional tendencies, as well as cultural roles.
- Examples: Homework assignments such as the Genogram, violence autobiography, and timeline.
- M. Offender understanding and use of appropriate communication skills
1. Demonstrates nonabusive communication skills that include how to respond respectfully to the offender's partner's grievances and how to initiate and treat one's partner as an equal.
 2. Demonstrates an understanding of the difference between assertive, passive, passive aggressive, and aggressive communication, and makes appropriate choices in expressing emotions.
 3. Demonstrates appropriate active listening skills.
- N. Offender understanding and use of "time-outs"
1. Recognizes the need for "time-outs" and/or other appropriate self-management skills.
 2. Understands and practices all components of the time-out.
 3. Demonstrates and is open to feedback regarding the use of time-outs in therapy.
- O. Offender recognition of financial abuse and management of financial responsibility
1. Consistently meets financial responsibilities such as treatment fees, child support, maintenance, court fees, and restitution. The MTT may choose to require the offender to provide documentation that demonstrates financial responsibilities are being met.
 2. Maintains legitimate employment, unless verifiably or medically unable to work.
- P. Offender eliminates all forms of violence and abuse
1. The offender does not engage in further acts of abuse and commits no new domestic violence offenses or violent offenses against persons or animals.
- Q. Offender prohibited from purchasing, possessing, or using firearms or ammunition.
1. An exception may be made if there is a specific court order expressly allowing the offender to possess firearms and ammunition. In these cases, it is incumbent upon the offender to provide a copy of the court order to the Approved Provider to qualify for this modification of the Offender Contract. It is then incumbent upon the Approved Provider to design treatment planning to address storage of the firearm, (such as firearm shall not be allowed in the home) and other factors related to offender risk, safety planning and victim safety.

- R. Offender identification and challenge of cognitive distortions that plays a role in the offender's violence.
1. Offender demonstrates an understanding of distorted view of self, others, and relationships (e.g. Gender role stereotyping, misattribution of power and responsibility, sexual entitlement).

Discussion Point: For offenders whose abusive thought patterns are entrenched, an expanded adaptation of this competency may need to be designed and utilized. The degree of offender cognitive distortions fall on a continuum from more distorted to less distorted, and different offenders have different levels of distortions. There may be a need for additional clinical work that addresses the distorted thought patterns specific to the offender.

VI. Additional Competencies

Additional competencies shall be required for offenders based on risk factors and individual treatment needs, as determined at the initial evaluation or during Treatment Plan Reviews. The following is a suggested list (not all inclusive) of potential additional competencies. Approved Providers and other MTT members may also design competencies based on offender risk or individual treatment needs. Additional competencies shall be approved by MTT consensus. Some offenders may need more expanded versions of the core competencies or an additional competency may be created. The MTT may also design additional competencies based on the treatment intake evaluation and/or degree of progress in treatment. These additional competencies are intended to be based on individual offender needs, issues and risk. The following are some examples of additional competencies that may be utilized or designed.

- A. Offender understanding and demonstration of responsible parenting
1. Consistently fulfills all applicable parenting responsibilities such as cooperating with the child/children's other parent regarding issues related to parenting, following established parenting plan, and appropriately using parenting time including the safety and care of the child/children.
 2. Demonstrates an understanding that abuse during pregnancy may present a higher risk to the victim and unborn child. The offender demonstrates sensitivity to the victim's needs (physical, emotional, psychological, medical, financial, sexual, social) during pregnancy.

Discussion point: If the offender has abused any pregnant partner and the current partner is pregnant, this may need to be addressed as an additional competency.

3. Demonstrates appropriate interaction with the children and partner in a co-parenting or step-parenting situation (Bancroft & Silverman, 2002).

Discussion Point: Some offenders may not be appropriate for parenting as determined by a court order or other agreement (e.g. divorce proceedings, dependency and neglect court findings, or protection/restraining order requirements). In these cases, the Approved Provider, referring criminal justice agency and the Treatment Victim Advocate shall be apprised of this information and the Treatment Plan shall be adjusted accordingly.

- B. Offender identification of chronic abusive beliefs and thought patterns that support his/her ongoing abusive behavior.

Discussion Point: One particular cognitive distortion associated with risk of reoffense is the offender's exaggerated negative view of the his/her partner (or former partner). The offender has to recognize and address that this negative distorted view of the victim may have developed as a reaction to the victim's resistance to the offender's abuse and control (Bancroft & Silverman, 2002).

- C. Offender identification of pro-social and/or community support and demonstration of the ability to utilize the support in an appropriate manner.

Discussion Point: Based on the offender's need and risk, the Approved Provider may require the offender to identify appropriate individuals who can offer positive, pro-social support, such as an individual from a 12-Step Program, or community or faith-based organization. The identified support person cannot be the victim or current partner of the offender. Based on treatment needs (e.g. social isolation and lack of pro-social support) and ongoing Treatment Plan Reviews, the Approved Provider may require the offender to share details of the offending behavior and Personal Change Plan with a support person, and verify having done so (Andrews & Bonta, 1994).

- D. Offender's consistent compliance with any psychiatric and medical recommendations for medication that may enhance the offender's ability to benefit from treatment and/or reduce the offender's risk of reoffense.

- E. Offender's consistent compliance with any alcohol or substance abuse evaluation and treatment that may enhance the offender's ability to benefit from treatment and/or reduce the offender's risk of reoffense.

5.08 Offender Discharge

There are three types of discharge:

- I. Treatment Completion
- II. Unsuccessful Discharge from Treatment
- III. Administrative Discharge from Treatment

For each type of discharge, responsibilities of the offender, MTT, and Approved Provider are identified.

MTT consensus is required for discharge. In the event there is a lack of consensus, refer to *Standard 5.02 VII C.*

Discussion Point: Protection of the victim is priority. Therefore if the only information that is available that would prevent offender discharge is victim information and the MTT has determined that victim information cannot be revealed in order to protect the victim and there are no other ways to validate or confirm, then the MTT may determine that discharge is appropriate.

I. Treatment Completion

A. Offender Responsibilities, Progress in Treatment

The offender has demonstrated adherence to all of the following:

1. All required competencies
2. Conditions of the Treatment Plan
3. Conditions of the Offender Contract

B. MTT Responsibilities

The MTT has verified all of the following:

1. The offender has demonstrated all required competencies, Offender Contract requirements, and other conditions of his/her Treatment Plan;
2. The offender has completed all required Treatment Plan Reviews (not to include the intake evaluation);
3. The required consultation has occurred at each stage of treatment;
4. No additional risk factors have been identified or been reported through other sources outside of offender contact as relevant (e.g. social services, psychiatrist, new partner, parents, or clergy);

Discussion Point: The MTT may determine who is appropriate or relevant to contact on a case by case basis throughout treatment as well as prior to discharge.

1. Reduction of risk as reported by Approved Provider, using information from other MTT members, and
2. MTT consensus regarding discharge. The definition of consensus is that members are in agreement.

C. Approved Provider Responsibilities

The Approved Provider shall create a discharge summary to be provided to probation and/or the court. This summary shall document findings from Standard 5.09 I A & B and include at a minimum the following:

1. Type of discharge
2. Information regarding the level(s) of treatment
 - a. Initial level of treatment
 - b. Any changes to level of treatment
 - c. Level of treatment upon completion
3. Information regarding risk factors
 - a. Initial risk factors
 - b. Any changes to risk factors during treatment, increase or decrease
 - c. Identification of current risk factors
4. Verification that the offender Treatment Plan components, offender competencies, and criteria for treatment completion have been demonstrated
5. Duration of offender treatment
6. Summary of verification of MTT responsibilities for discharge (Refer to *Standard 5.09 I B*)
7. Any current or ongoing concerns identified by the MTT.

II. Unsuccessful Discharge from Treatment

A. Offender Responsibilities, Progress in Treatment

Offender has not met responsibilities and requirements related to one or more of the following:

1. All required competencies
2. Conditions of the Treatment Plan
3. Conditions of the Offender Contract

B. MTT Responsibilities

The MTT has verified all of the following:

1. The offender's lack of progress related to offender demonstrating required competencies, compliance with Offender Contract requirements, and other conditions of the Treatment Plan.
2. Completion of any required offender Treatment Plan Reviews (not to include the intake evaluation).
3. Required consultation has occurred at each stage of treatment.
4. Any additional risk factors that have been identified or been reported through other sources outside of offender contact as relevant (e.g. social services, psychiatrist, new partner, parents, or clergy).

Discussion Point: The above list of other sources is intended to be a guideline regarding whom to contact. The MTT may determine who is appropriate or relevant to contact on a case-by-case basis throughout treatment as well as prior to discharge.

5. Any increase in level of risk as reported by Approved Provider, using information from other MTT members.
6. MTT consensus regarding unsuccessful discharge. The definition of consensus is defined as the agreement among the MTT members.

C. Approved Provider Responsibilities

The Approved Provider shall create a Discharge Summary to be provided to probation and/or the court. This summary shall document findings from Standard 5.09 II. A and B and include at a minimum the following:

1. Type of discharge

Identify offender deficiencies and resistance related to:

- a. Required offender competencies
- b. Treatment Plan
- c. Offender Contract

Approved Provider has clinically documented the offender's noncompletion of Treatment Plan requirements, including, but not limited to, unwillingness to master all required core and additional competencies as identified in the offender's Treatment Plan and Offender Contract requirements.

2. Information regarding the level(s) of treatment

- a. Initial level of treatment
- b. Any changes to level of treatment
- c. Level of treatment at discharge

3. Information regarding risk factors
 - a. Initial risk factors
 - b. Any changes to risk factors during treatment
 - c. Identification of current risk factors
4. Approved Provider has documented the offender is inappropriate for continued treatment due to the presence of Significant Risk Factors, offender denial, and/or offender lack of progress in treatment.
5. Duration of offender treatment
6. Summary of verifications of MTT responsibilities for discharge (Refer to *Standard 5.09 II. B*)
7. Any current or ongoing concerns identified by the MTT
8. MTT consensus for this discharge status and reasoning is documented.
9. Identification of whether the court supervision period has ended and offender has refused to continue in treatment.

III. Administrative Discharge from Treatment

A. Offender Responsibilities

Offender shall provide verification of the need for an administrative discharge as requested by the MTT.

B. MTT Responsibilities

MTT shall verify the reason for administrative discharge.

1. Reasons may include, but are not limited to, circumstances such as the offender is on medical leave, the offender's employment has transferred the offender to a new location, military deployment, or there is a clinical reason for a transfer.
2. MTT consensus for this discharge status and reasoning is documented.

C. Approved Provider Responsibilities

The Approved Provider shall create a Discharge Summary to be provided to probation and/or the court. This summary shall document findings from Standard 5.09 III A and B and include at a minimum the following:

1. Type of discharge
2. Information regarding the level(s) of treatment
 - a. Initial level of treatment
 - b. Any changes to level of treatment
 - c. Level of treatment at discharge
3. Information regarding risk factors
 - a. Initial risk factors
 - b. Any changes to risk factors during treatment. Identification of current risk factors
4. Degree to which the offender Treatment Plan components, offender competencies, and criteria for treatment completion have been demonstrated
5. Duration of offender treatment
6. Summary of verifications of MTT responsibilities for discharge (Refer to *Standard 5.09 III B*)
7. Any current or ongoing concerns identified by the MTT
8. MTT consensus for this discharge status and reasoning is documented.

IV. Transferring Programs

Approved Providers shall not accept an offender transferring into their program without the responsible referring criminal justice agency's written approval. The receiving Approved Provider, the previous Approved Provider, and the MTT shall perform case coordination, including discussion of any additional treatment that may be required. The final recommendation for treatment shall be determined by the new MTT. The receiving Approved Provider shall require the offender to sign a release of information, allowing the previous Approved Provider to submit a copy of the discharge summary. The previous Approved Provider is required to provide a copy of the discharge summary immediately upon receipt of the release to the receiving Provider.

The Approved Provider shall create a Discharge Summary to be provided to probation and/or the court. This summary shall document findings from Standard 5.09 III. A and B and include at a minimum the following:

- A. Type of discharge
- B. Information regarding the level(s) of treatment
 - 1. Initial level of treatment
 - 2. Any changes to level of treatment
 - 3. Level of treatment at discharge
- C. Information regarding risk factors
 - 1. Initial risk factors
 - 2. Any changes to risk factors during treatment
 - 3. Identification of current risk factors
- D. Degree to which the offender Treatment Plan components, offender competencies, and criteria for treatment completion have been demonstrated
- E. Duration of offender treatment
- F. Summary of verifications of the MTT responsibilities for discharge (Refer to *Standard 5.09 III B*)
- G. Any current or ongoing concerns identified by the MTT
- H. Consensus for this discharge status and reasoning is documented.

V. Re-admission into treatment with the same Approved Provider: Prerequisites for offenders re-entering treatment with an Approved Provider:

- A. Consensus of the MTT to re-admit the offender into treatment.
- B. Consensus of MTT regarding placement in treatment, including updated evaluation and DVRNA if appropriate.
- C. The Approved Provider shall review and update the Offender Contract and Treatment Plan with the offender.

5.09 Couple's Counseling

- I. Couple's counseling is not a component of domestic violence treatment. The offender is the client in offender treatment, not the couple, and not the relationship. Therefore, couple's counseling is not permitted during domestic violence offender treatment.
- II. The offender is prohibited from participating in any couples counseling while in offender treatment. This includes any joint counseling that involves the offender and the victim.

Because of the potential therapeutic challenges of concurrent treatment along with dangers and risk to victim safety, this standard further clarifies that offenders will not participate in marriage or couple's counseling of any kind with anyone with the victim outside of offender treatment.

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6.0 Offender Confidentiality

For information regarding victim confidentiality refer to *Standard 7.04*.

The Approved Provider shall ensure that the offender understands the limits of confidentiality.

6.01 Offenders who have committed domestic violence related offenses must waive confidentiality for purposes of evaluation, treatment, and supervision and case management. The offender must be fully informed of alternative dispositions that may occur in the absence of consent/assent.

6.02 Effective supervision and treatment of offenders is dependent upon open communication among the Multidisciplinary Treatment Team (MTT) members. Confidentiality in offender treatment differs from traditional therapy settings due to the criminal justice involvement and supervision. Communication and collaboration among MTT members are requirements of treatment and must be made clear to the offender.

Waivers of confidentiality will be required of the offender by the (1) conditions of probation, parole, and/or community corrections, and 2) the Approved Provider-Offender Contract.

In accordance with the §12-43-218, C.R.S., Approved Providers shall safeguard the confidentiality of offender information from those for whom waivers of confidentiality have not been obtained.

Offender waivers of confidentiality shall also extend to the victim, specifically with regard to (1) the offender's degree of compliance with treatment and (2) information about risk, threats, and/or possible escalation of violence.

6.03 An Approved Provider shall obtain signed waivers of confidentiality based on the informed consent of the offender. If an offender has more than one therapist or Approved Provider, the waiver of confidentiality shall extend to all therapists treating the offender. The waiver of confidentiality shall extend to the Treatment Victim Advocate and/or victim's therapist (this may include past or current partners when applicable) and local community domestic violence victim program. The waiver of confidentiality shall extend to the supervising officer, including the victim assistance officer. It shall also extend to all members of the MTT and, if applicable, to the Colorado Department of Human Services and other individuals or agencies responsible for the supervision of the offender and/or involved in family reunification or protection of children.

***Discussion Point:** All members of the MTT shall use discretion in disseminating information to current or former partners. Consideration for victim safety shall guide the decisions.*

6.04 An Approved Provider shall notify all offenders of the limits of confidentiality imposed on therapists by the mandatory reporting law §19-3-304, C.R.S.

6.05 As clinically appropriate an Approved Provider may obtain a limited waiver of confidentiality for communications with other parties in addition to those described in this standard.

7.0 Victim Advocacy

Introduction

Resources and forms for victim advocacy are available on the DVOMB website.

Victim advocacy in offender treatment is critical in order to continually address victim safety issues. Victim safety and offender risk are fluid and dynamic. Shared information among professionals involved in the case and shared decision making are vital in this work. The primary goals of offender treatment are cessation of abusive behaviors and victim safety. (*Guiding Principles 3.0*) both of these are necessary, critical, interdependent parts of treatment.

Victim and community safety are the highest priorities of the *Standards and Guidelines*. This should guide the responses of the criminal justice system, victim advocacy, human services and domestic violence offender treatment. Whenever the needs of domestic violence offenders in treatment conflict with the needs of community (including victim) safety, community safety takes precedence. (*Guiding Principles 3.01*)

7.01 Treatment Provider Responsibilities

I. Victim Advocate

All offender Treatment Providers shall have a qualified, designated professional in the role of Treatment Victim Advocate.

II. Dual Roles

Treatment Providers shall not have a dual role with her/his advocate as defined in section 7.03 VIII. Dual Roles.

III. Victim Advocate Qualifications

(Reference 7.03 Qualifications of Treatment Victim Advocate)

IV. Notification to DVOMB Office

- A. Treatment Providers shall keep DVOMB staff informed of the name of the Treatment Victim Advocate, current contact information and verification of the Treatment Victim Advocate's qualifications.
- B. Additionally, a confirmation letter from the advocate verifying that advocacy is being provided per the *Standards and Guidelines* shall be provided to DVOMB staff.

V. Cooperative Relationships

Providers shall also maintain cooperative working relationships with domestic violence victim services.

7.02 Role of Treatment Victim Advocates

The Treatment Victim Advocate holds the key to the confidentiality of the victim and assists the victim in determining not only whether information will be shared, but also what specific information can be shared with the MTT. Representing victim experiences and perspectives, whether the victim has been contacted or not, is unique to victim advocates. The victims of these intimate, complex and dangerous crimes require a specialized victim advocacy approach. Victim advocates are highly trained, experienced, knowledgeable and skilled professionals.

Discussion Point: It is the expectation of the DVOMB that individuals also governed under the Mental Health Practice Act (Title 12, Article 43 of the Colorado Revised Statutes) will also comply with the statutes, rules, and policies of their Governing Board.

I. Treatment Victim Advocates are an Integral Member of the MTT and Work with the MTT and the Treatment Provider to:

- A. Function as a liaison and bridge between the victim and the MTT
- B. Participate in case problemsolving

Discussion Point: A facet of the Treatment Victim Advocate's role on the MTT includes identifying erroneous beliefs or attitudes that, if present, may be harmful to victims. This includes encouraging deeper dialogue for the entire MTT to understand the meanings and purposes of behaviors of both victims and offenders. MTT members use all of this information to have an improved understanding of the case, even when the information is not aligned.

- C. Provide specialized perspectives on victim trauma
- D. Provide specific knowledge or expertise about victim safety
- E. Educate the MTT on trauma informed considerations for victims

7.03 Qualifications for Treatment Victim Advocates Working with an Offender Treatment Program

Treatment Victim Advocates shall be familiar with these entire *Standards and Guidelines*.

I. All Providers Shall Have a Qualified, Designated Professional in the Role of Treatment Victim Advocate

II. Fully Qualified Treatment Victim Advocate Requirements

- A. Basic certification from the Colorado Advocate Certification Program (CACP) or National Organization for Victim Assistance (NOVA) National Advocate Credentialing Program is required. These programs are administered through the Colorado Organization for Victim Assistance (COVA) and NOVA: (<http://www.coloradocrimevictims.org/colorado-advocate-certification-program-cacp.html>) or (<http://www.tryNOVA.org/>)

- B. Training hours per COVA or NOVA program with focus on the following as electives: Confidentiality, safety planning, co-occurrence of domestic violence and child abuse, sexual assault, elder abuse, DVRNA, MTT, DVOMB *Standards and Guidelines*, domestic violence offender issues, domestic violence offender treatment competencies, risk/lethality assessment, and special victim and offender populations
- C. Experiential hours according to COVA or NOVA requirements
- D. Peer consultation is strongly encouraged with other fully qualified Treatment Victim Advocates, or consultation with local victim services. Peer consultation may include:
 - 1. Sharing information about training opportunities
 - 2. Sharing information regarding resources
 - 3. Confidentiality issues
 - 4. Advocacy on behalf of a specific population
 - 5. Technical assistance, safety planning, brainstorming difficult cases

III. Entry Level Treatment Victim Advocates

A Provider may utilize an “Entry Level Treatment Victim Advocate” who meets the following qualifications:

- A. Training Hours:
 - 1. A minimum of 30 initial hours of training in domestic violence to include: victim advocacy, domestic violence dynamics, victimization and safety planning
 - 2. The remaining 30 hours of training required for Fully Qualified Treatment Victim Advocate shall be achieved within the first year of work as a domestic violence Entry Level Treatment Victim Advocate
- B. Experiential Hours:
 - 1. 70 hours of experience working with domestic violence victims. These hours may be achieved through any combination of employment, volunteer work, or internships.
 - 2. The remaining 70 experiential hours required for a Fully Qualified Treatment Victim Advocate shall be achieved within two years.
- C. Peer Consultation: is strongly encouraged with other Fully Qualified Treatment Victim Advocates, or consultation with local victim services. Peer Consultation may include:
 - 1. Sharing information about training opportunities
 - 2. Sharing information regarding resources
 - 3. Confidentiality issues
 - 4. Advocacy on behalf of a specific population
 - 5. Technical assistance, safety planning, brainstorming difficult cases
- D. The COVA CACP basic certification shall be applied for by the end of the second year of working as an Entry Level Advocate. (NOVA certification is also accepted.)

IV. Specific Offender Populations

- A. Specific offender populations are defined as a group of individuals that share one or more common characteristics such as race, religion, ethnicity, language, gender, age, culture, sexual orientation and/or gender identity that would allow for the group to be considered homogenous (10.01).

- B. If Approved Providers are specializing in a specific population of offenders, the advocate shall have a minimum of seven (7) hours of training on each specific offender and victim population.

V. Continuing Education and Renewal of Advocacy Certification

- A. Renewal of COVA or NOVA certification every 2 years
- B. Treatment Victim Advocates shall submit proof of this to the Treatment Provider

VI. Victim Advocates Shall Be Knowledgeable About Resources

Pertinent to this work and victims' needs including but not limited to: domestic violence shelters, address confidentiality program, behavioral health services, sexual assault support services, and culturally and linguistically appropriate services.

VII. Treatment Victim Advocates Shall Be Violence Free

Violence free is defined as:

- A. No criminal history that would impact the Treatment Victim Advocate's ability to be an effective advocate. (a minimum of CBI criminal history search)
- B. The Treatment Victim Advocate does not engage in any acts of physical violence, does not verbally abuse, threaten, coerce or intimidate other people. An advocate does not deny personal responsibility for her/his actions or blame other persons for her or his actions.
- C. Additionally, any history of victimization and trauma cannot impede the advocate's ability to be an effective advocate.

VIII. Dual Roles

- A. Treatment Victim Advocates shall not have a dual role with her/his Treatment Provider, the offender or the victim.

Discussion Point: It is the expectation of the DVOMB that individuals also governed under the Mental Health Practice act (Title 12, Article 43 of the Colorado Revised Statutes) will also comply with the statutes, rules, and policies of their Governing Board.

- B. The Treatment Victim Advocate cannot be in another relationship with the Provider (such as a spouse or relative).
- C. The Treatment Victim Advocate cannot also be working in other therapeutic or case management capacities with the domestic violence offenders or victims within the same treatment agency
- D. The Treatment Victim Advocate shall not also be the therapist for the victim.

Discussion Point: Dual relationships can create barriers to an open and honest dialogue. The advocate may be concerned about raising issues that may potentially impact the personal or other relationship with the Provider.

Dual roles may be confusing to a victim and impact their ability to trust the advocate.

7.04 Initial and Ongoing Advocacy

Offender treatment is not contingent on victim contact and the offender shall not be used as a mechanism to reach the victim.

I. Treatment Victim Advocate's Initial Contact with the Victim

- A. Timing of the initial contact with the victim is determined by the Treatment Victim Advocate, based on information available and victim safety considerations. Any contacts or attempts to contact victims should be documented by the advocate in a file separate from the offender file.
- B. Treatment Victim Advocates may need to find recent contact information for victims through avenues such as: the probation department, law enforcement agency or the district attorney's office. Treatment Victim Advocates should not attempt to locate victims using social media or similar electronic/digital communication avenues.
- C. On the initial contact with a victim, the Treatment Victim Advocate shall inform the victim of the information that can be provided during advocacy contacts and explain informed consent and any mandatory reporting obligations (Reference 7.07 *Confidentiality Section*). Resources for advocates are available on the DVOMB website.
 1. Reporting of suspected abuse or neglect of children and at risk elders
 - a. All Treatment Victim Advocates have a responsibility to report and shall report suspected abuse or neglect of children or at risk elders whether or not they are legally mandated to report. C.R.S. 19-3-302, C.R.S. 26-3.1-110
 - b. Advocates shall inform victims of this upon initial contact and as appropriate during victim contacts.
 - c. Advocates shall inform the Treatment Provider when a report has been made.
- D. The advocacy contacts shall address the following:
 1. A brief explanation of who the Treatment Victim Advocate is and why they are making contact
 2. Explanation of confidentiality, including limitations
 3. Whether or not the victim wishes to be contacted including preferred and most secure method of contact. Social media or similar electronic/digital communication avenues are not appropriate ways to contact victims, as confidentiality may be jeopardized.
 4. General overview of the domestic violence offender treatment process
 5. General domestic violence information, including warning signs and risks
 6. Any concerns about safety the victim may have
 7. Referrals & resources

II. Initial and Ongoing Discretionary Areas

The following types of information can be shared with a victim at the discretion of the Treatment Victim Advocate:

Upon further assessment of victim safety and needs, advocates may use discretion on a case by case basis to determine the most appropriate information to be shared. When working with a co-defendant or a victim that the advocate believes may be a perpetrator, victim safety always prevails, refer to the Guiding Principles 3.0.

- A. Offender status in treatment, offender absences, discharge or changes in treatment plan, time and day of offender's treatment group and/or individual sessions with Treatment Provider
 - B. Information about Protection Orders
 1. Individualized safety planning (intended to be fluid and changing as risk changes):
 2. Safety planning if the victim is remaining in the relationship & safety planning if the victim is leaving the relationship
 3. Safety planning specific to children who are either in or out of the home
 4. Duty to warn: Treatment Victim Advocates need to explore with the Treatment Provider whether the advocate has a legal duty to warn, due to differences in professional obligations.
 5. Well-being checks via law enforcement
 - D. Risk & abusive behavior patterns, both in general and that are specific to the offender
 - E. Information specific to specific populations (such as working with male victims and/or working with victims in same-sex relationships)
 - F. Responding to additional victim requests
 1. The role of the Treatment Victim Advocate in communication with the victim is to provide information regarding offender treatment, provide support, and provide information and referrals to resources.
 2. Responding to additional requests from victims should be guided by confidentiality, safety and based on the specifics of each case. Treatment Victim Advocates are also encouraged to seek ongoing training, supervision and refer to the Treatment Provider agency policies for additional clarification of issues.
- 7.04 Required Approved Treatment Provider and Treatment Victim Advocate Coordination and Consultation

7.05 Required Approved Treatment Provider and Treatment Victim Advocate Coordination and Consultation

I. Required Provider Coordination

- A. It is the Treatment Provider's responsibility to obtain the input of the Treatment Victim Advocate for MTT meetings, and to include the advocate in the scheduling of MTT meetings. The purpose is to obtain the Treatment Victim Advocate's expertise and perspective, not necessarily specific victim information.
- B. There are multiple methods that Treatment Victim Advocates and Treatment Providers can utilize to communicate with one another, given specific circumstances while considering confidentiality. (Please refer to the DVOMB website Treatment Victim Advocate page and the document: *Inclusion of Treatment Victim Advocates in MTT*)

- C. In addition to communication required in *Section 7.06 Treatment Victim Advocacy and the MTT*, Providers also have the responsibility to keep MTT members, which includes Treatment Victim Advocates, informed regarding pertinent issues during treatment.

II. Information Sharing Requirements of Treatment Providers

- A. In order to optimize victim safety and victim considerations, Treatment Providers shall provide victim contact information, if available, from the offender intake to the Treatment Victim Advocate as soon as it is available.
- B. Prior to the offender beginning treatment, Treatment Providers shall provide additional information to the Treatment Victim Advocate. That information will include at a minimum:
1. Victim contact information (offenders will not be required to provide this, if it impacts victim safety)
 2. Victim and offender relationship status, such as living together, separated, civil or criminal matters
 3. Whether children are involved (such as custody, visitation)
 4. Offender's group or individual treatment day and time
 5. Confirmation that the release is signed by the offender to contact the victim
 6. The offender's initial level of treatment and risk factors from the DVRNA
 7. Status of protection order (civil order, criminal order, does it include no contact order? Any modifications)
 8. Police report on the current offense
- C. In addition to the MTT communication and decision requirements (reference 7.06); the Treatment Provider is responsible for providing the following information to the Treatment Victim Advocate throughout treatment:
1. Offender Absences
 2. Changes in Offender Risk
General concerns regarding immediate risk or imminent danger shall be reported to the Treatment Victim Advocate immediately. In the event that the Treatment Provider initiates a duty to warn, this information shall also be provided to the advocate. (Providers have a duty to warn, refer to *Standard 11.09*)
 3. All offender absences shall be reported within 24 hours of the absence to the Treatment Victim Advocate.
 - a. If an offender has more than three absences, the Provider shall consult with the Treatment Victim Advocate as part of the MTT to determine any needed consequences or modifications to the offender's Treatment Plan. The MTT may require the offender to provide documentation of reasons for absences.
 4. Violations of Offender Contract:
At a minimum, the Treatment Provider shall give written or verbal notification of the violations to the Treatment Victim Advocate. Further consultation between the Treatment Provider and Treatment Victim Advocate shall occur as needed to ensure victim and community safety. (Reference *Offender Contract 5.05 II*)

III. Guidelines for Treatment Victim Advocates Regarding Communication and Consultation with the Provider

Regardless of victim involvement, advocates have a responsibility to communicate with the Provider (reference 7.01)

A. Confidentiality and Victim Safety (Reference 7.07)

Confidentiality and victim safety guides the work of the Treatment Victim Advocate in communication with the Provider.

If the victim does not want information communicated to the Treatment Provider, then the information remains confidential, with the exception of reporting suspected abuse or neglect of children or at risk elders to the local county Department of Human Services.

B. Consultation with the Provider

1. If the victim does give verbal or written permission, the advocate can discuss offender behavior or victim concerns with the Provider. The Advocate and Provider will discuss ways the offender behaviors can be addressed in treatment, without the offender knowing the information was provided by the victim. The offender shall not be given any indication that the victim provided information, as protecting information shared by the victim is critical.
2. If the victim does not give permission for the advocate to discuss specific information with the Provider, the advocate shall respect the victim's wishes. The advocate can discuss general victim considerations but shall not discuss specific victim information.
 - a. However the advocate can inquire about offender progress and the nature of participation in treatment. The advocate and Provider can identify any offender deficiencies or non-compliance that the Provider can address more specifically.
 - b. The advocate can provide general education on domestic violence and victim dynamics to the Provider.

IV. Provider Responsibilities when Utilizing a New Advocate

A. Treatment Provider Responsibilities

When an advocate ends service with a Provider or treatment agency, the Provider is responsible for coordinating victim advocacy services between the outgoing advocate and the new advocate.

Sharing of victim and offender information from the outgoing advocate to the new advocate is important to ensure victim safety and to promote a smooth transition.

B. Treatment Victim Advocate Responsibilities

The outgoing Treatment Victim Advocates shall make every effort to transition the duties of the advocate leaving the position to the new advocate and to ensure that victim safety and victim confidentiality are upheld.

7.06 Treatment Victim Advocacy and the Multi-Disciplinary Treatment Team (MTT)

I. Importance of Treatment Victim Advocacy

Treatment Victim Advocates are integral to the purpose of the MTT. They represent victim perspectives and considerations regarding offender treatment and accountability, whether or not victim contact is made. Treatment Victim Advocates broaden the information available for making the most informed decisions by the MTT. They offer balanced perspectives and Treatment Victim Advocates view domestic violence cases through the lens of victim safety, which is the priority of offender treatment.

Members of the MTT are responsible for being professional, respectful and inclusive of other MTT members. MTT members acknowledge the expertise and perspective that each member brings to the work.

- A. Not only do Treatment Victim Advocates provide critical perspectives, but it is crucial for MTT members to provide information to the Treatment Victim Advocate for effective coordination of treatment.
- B. Each member of the MTT is responsible for victim safety and consideration of the impact of treatment decisions on victims.

II. Role of MTT Members (Excerpt from Standard 5.02 MTT Members)

As a member of the MTT, Treatment Victim Advocates shall be familiar with the entire Standards.

- A. The Treatment Victim Advocate is a member of the MTT and participates in MTT decisions.
- B. MTT Membership
The MTT consists of Approved Provider, responsible referring criminal justice agency, and Treatment Victim Advocate at a minimum. Other professionals relevant to a particular case may also be a part of the MTT such as human services, child welfare, and child protection services.
- C. MTT Purpose
The MTT is designed to collaborate and coordinate offender treatment. Therefore the work of the MTT needs to include staffing cases; sharing information; and making informed decisions related to risk assessment, treatment, behavioral monitoring, and management of offenders. The MTT, by design, may prevent offender triangulation and promote containment.
- D. MTT Training
In the best interest of having an effective MTT, team members should successfully complete training specific to domestic violence in each of the following areas:
 - 1. Dynamics of domestic violence
 - 2. Dynamics of domestic violence victims
 - 3. Domestic violence risk assessment
 - 4. Offender treatment

The MTT may also want to consider cross training to further develop team competency.

- E. MTT Communication
The MTT will determine the most effective methods and frequency of communication, which can include face to face and/or non-face to face contact. Information regarding frequency can be reviewed in the *Treatment Plan Review Intervals in Standard 5.07*. (Also reference DVOMB website MTT resources document: inclusion of victim advocates)
- F. Offender Containment
This is one of the goals of the MTT. The MTT will collaborate to establish consequences for offender noncompliance.

G. Victim Confidentiality

The MTT shall make victim safety and victim confidentiality its highest priority. However, when the Treatment Victim Advocate makes contact with the victim, the victim shall be informed regarding the limits of confidentiality.

1. The MTT has the responsibility to protect confidential information that cannot be discussed during the MTT process. Specific victim information may be shared with the MTT only after written consent has been given by the victim (Refer to *Standard 7.07 II.C.*) Therefore, the Treatment Victim Advocate will not be expected to violate victim confidentiality.
2. In cases where there is not written consent or where the advocate has not had contact with the victim, the Treatment Victim Advocate provides perspectives and insights regarding victim issues in general, not regarding a specific victim. (Please note: Some information is not confidential such as homicidal, suicidal ideation/intent, and child abuse or neglect.) (Refer to Standard 7.0 in its entirety.)

Discussion Point: Protection of the victim is priority, therefore, if the only information available that would prevent offender discharge is victim information, and the MTT has determined that victim information cannot be revealed in order to protect the victim, and there are no other ways to validate or confirm, then the MTT may determine that discharge is appropriate.

H. MTT Consensus

1. Consensus is defined as the agreement among the team members. The MTT shall have consensus as its goal in managing offenders.
The MTT shall reach consensus for the following phases of treatment, at a minimum: initial placement in treatment, when treatment planning indicates a change in Level of offender treatment, and discharge. While there is acknowledgment that there is a supervising agent for the court, the intent and goal are to work collaboratively.
2. MTT members are encouraged to discuss and attempt to resolve differences in order to achieve consensus. An effort should be made by MTT members to meet in person to work toward resolution.

7.07 Victim Confidentiality Section

I. Importance of Victim Confidentiality

- A. When a victim chooses not to provide information, the approved Provider, the MTT and the Treatment Victim Advocate shall honor the victim's decision and right to control their own information.

Discussion Point: it is the Treatment Victim Advocate's responsibility to know the different types and roles of other advocates and victim assistants in community based organizations or in the criminal justice system. Other advocates have different duties and requirements in regard to confidentiality of victim information. (Reference DVOMB website MTT Resources Document: Explanations of the Different Advocate Roles in Colorado)

- B. It is important for advocates to explain the benefits and limitations of confidentiality to the victims they assist (reference 7.04 I.C.1.).
- C. When a victim chooses not to provide information, the approved Provider, the MTT and the Treatment Victim Advocate shall honor the victim's decision and right to control their own information.

II. **The Duty of Confidentiality**

Treatment Victim Advocates have a responsibility to take steps to protect victims' privacy and safety.

- A. Treatment Victim Advocates have a responsibility to not reveal any confidential information relating to assistance provided on behalf of, or communications with, a victim of domestic violence. This is the Treatment Victim Advocate's duty of confidentiality to the victim.

Treatment Victim Advocates shall know the Treatment Provider's/agency's confidentiality policies and procedures.

B. Exceptions to victim confidentiality

1. Reporting of suspected abuse or neglect of children and at risk elders:

- a. All Treatment Victim Advocates have a responsibility to report and shall report suspected abuse or neglect of children or at risk elders whether or not they are legally mandated to report. C.R.S. 19-3-302, C.R.S. 26-3.1-110
- b. Advocates shall inform victims of this upon initial contact and as appropriate during victim contacts.
- c. Victims should be notified when a report is made for suspected child abuse or neglect or elder abuse, or when their information is shared under a court order
- d. Advocates shall inform the Treatment Provider when a report has been made.

2. Informed consent to a release of information

- a. Explain to victims her/his options regarding providing consent before their information is shared by the Treatment Victim Advocate with anyone else, including other members of the MTT
- b. Victim consent should be informed, written, and reasonably time-limited
 - i. Victim consent may be obtained *verbally* for information being shared *only* with the Treatment Provider; advocates shall document victims verbal consent and all conditions that apply.
- c. Treatment Victim Advocates shall honor victims' rights and choices regarding what, if any, victim information will be shared, and with whom including:
 - i. What specific victim information the advocate will be sharing
 - ii. Who the information is to be shared with
 - iii. How that information may be utilized
 - iv. When that information will be shared
 - v. The time period for the release

3. Court ordered release of information

The Treatment Victim Advocate or the advocate's records could be subpoenaed (reference 7.08 I.C.)

C. Victim Releases of Information

(A sample release form is available on the DVOMB website)

1. A release of information from the victim is not required for advocacy to be provided by a Treatment Victim Advocate.
2. When a victim requests that information be shared with the offender or the MTT:
 - a. The Treatment Victim Advocate is responsible for exploring with the victim the possible range of consequences of sharing the information.
 - b. The Treatment Provider and MTT need to consider how to effectively address the victim's concerns in order to consider the impact to the victim and victim safety. The information might not be directly shared with the offender, but rather the offender's treatment plan may be modified to address the issues of concern.
 - c. The advocate will inform the victim of the MTT plan for addressing the victim's concerns and modify the safety plan accordingly.
 - d. A written release from the victim is required to share the information with the MTT and the offender.
 - e. Approved Providers shall verify that the Treatment Victim Advocate has obtained a written release of confidentiality from the victim before victim information can be shared with the offender or with the MTT.
3. Advocates shall accept a victim's verbal request to withdraw a release. The advocate shall obtain verification in writing from the victim as soon as possible.
4. Advocates shall not accept a release of information form from another agency in lieu of a release of information from their own Treatment Provider/agency.

General Discussion Point: *whenever releasing information about a victim, Treatment Victim Advocates and Treatment Providers should keep in mind the "minimum necessary concept". This means that even with a release or when filing a mandated report, share only the information necessary to accomplish the victim's purpose or to meet the requirements of the reporting obligation. The time limit on the release of information should be the minimum amount of time necessary to meet the victim's needs*

D. Treatment Victim Advocates shall not disclose personally identifying information about victims without a release of information.

E. Treatment Victim Advocates shall protect victim confidentiality throughout their work by sharing only the minimum amount of information necessary to meet the victim's needs, or in other words, on a "need to know basis".

General Discussion Point: *Treatment Victim Advocates should always consider the most protective privacy option. Before obtaining a release, advocates should determine whether there is another way to meet the victim's needs without revealing her/his confidential information. For example, connecting the victim to resources can be done by referral or by setting up a three-way call with the referral organization, and then leaving the call to allow the victim to have privacy and disclose her/his own information.*

7.08 Documentation and Record Retention

This section and the Victim Confidentiality Section are critically linked. (also reference 7.07 victim confidentiality)

I. Documentation

- A. Attempts to contact the victim need to be made throughout the course of treatment as requested by the victim. Attempts to contact the victim shall be documented.
- B. Confidential victim information shall be kept in a locked file separate from the offender file and access should be limited to advocates or to the Treatment Provider on a “need to know basis”.
 - 1. Electronic files that contain victims’ personal identifying information should be properly protected with limited, password-protected access.
 - 2. The Treatment Provider and advocate both have the responsibility to keep victim information in a separate file and properly protected.
- C. A victim shall be allowed access to her/his own information and be provided copies to her/him of her/his records upon request, and after doing adequate safety planning with the victim.

General Discussion Point: Treatment Victim Advocates need to be aware that all information written about a victim could potentially be subject to subpoena, court review and/or court ordered release. Advocates therefore should keep in mind the “minimum necessary concept”. For every piece of information that is recorded, advocates should consider: what is the purpose of recording this? Is this information necessary (a) to meet the victim’s needs? (b) to maintain agency functions?

II. Record Retention

- A. Advocates shall ensure that victim records are kept confidential. (Also reference Confidentiality Section 7.07 for additional considerations)
- B. Records of confidential victim information should only be maintained as long as is necessary to meet the victim’s needs.

8.0 Coordination With Criminal Justice System

8.01 Community Relationships: Approved Providers shall not practice in isolation. Approved Providers have a responsibility for developing a community approach to the provision of treatment. They shall maintain cooperative working relationships with domestic violence victim services, other Approved Providers and criminal justice programs, as well as alcohol/drug abuse programs and social services. In order to increase networking opportunities, it is recommended that Approved Providers attend community-based task force meetings.

8.02 Initial Contact: If a criminal justice agency makes a referral to an Approved Provider, that Approved Provider shall notify the criminal justice agency if the offender does not make contact within the time frame indicated. If no time frame was included with the referral, the Approved Provider shall notify the criminal justice agency within one week if the offender does not contact the Approved Provider.

8.03 Initial Appointment: Approved Providers shall make all reasonable attempts to provide an initial intake appointment within one week of contact by the offender.

8.04 Refusal to Admit: Approved Providers shall provide written documentation with reasons for refusal to admit to treatment to the responsible criminal justice agency within one week.

8.05 Transferring Programs: Approved Providers shall not accept an offender transferring into their program without the responsible criminal justice agency's written approval. The receiving Approved Provider, the previous Approved Provider, and the MTT will do case coordination, including discussion of any additional treatment that may be required. The final recommendation for treatment will be determined by the receiving Approved Provider.

8.06 Reporting: A monthly written summary report shall be sent to the offender's responsible criminal justice agency and shall include information on attendance, payment of fees, participation, offender progress, and any violations of the offender contract. The responsible criminal justice agency may request additional information regarding level of participation in treatment.

8.07 Absences: An offender may not be successfully discharged unless the offender has completed all the required Treatment Plan goals and met all discharge criteria. The responsibilities of the offender contract shall include the following agreements by the offender:

1. Offenders are responsible for attending treatment.
2. If an offender has more than three absences, the MTT shall consult to determine any needed consequences or modifications to the Treatment Plan. The MTT may require the offender to provide documentation of reasons for absences.
3. All offender absences shall be reported within 24 hours of the absence to the

Treatment Victim Advocate and the referring agency. The Treatment Victim Advocate will determine if the victim shall be notified according to the advocacy agreement with the victim (Refer to *Standard* Section 7.0 in its entirety). The referring agency may request a modification of the notification criteria.

8.08 Individual Treatment: Individual treatment (50 minute minimum) may be utilized on a case by case basis if the Approved Provider can demonstrate to the MTT an appropriate need for this treatment, such as crisis intervention, initial stabilization, or to address severe denial at the beginning of treatment. If individual treatment is the only form of treatment, it shall be for special circumstances. The Approved Provider shall document these special circumstances and the MTT consultation notes in the offender's case file.

8.09 Length of Treatment: These Standards incorporate different levels of treatment and focus on offender risk. The length of treatment is determined by individual offender risk and progress in treatment (Refer to Overview Chart on page 5-38).

8.10 Intensity of Treatment: The MTT shall have consensus when modifying the level of treatment for an offender and agree to related changes in the treatment plan.

- I. **There are three levels of treatment** that include Level A (low intensity), Level B (moderate intensity), and Level C (high intensity). Offenders are placed in a level of treatment based on the findings from the intake evaluation, offender treatment needs, and level of risk as identified by the DVRNA. Research demonstrates that matching offender risk to intensity of treatment reduces recidivism (Andrews & Bonta, 1994). Intensity of treatment is differentiated by frequency of clinical contact and content of treatment.
- II. **Initial Determination of Treatment Level** is recommended by the Approved Provider after the Offender Intake Evaluation has been completed and approved by the MTT. While some offenders may remain in the same level throughout treatment, there is also the ability to move offenders to a different level of treatment as needed. This is based on new information such as change in risk factors, mitigation of risk, continuing abuse, or denial.
 - A. Only offenders in Level C may be considered for a decrease in treatment level and then only to Level B.
 - B. No offenders in Level B or C are eligible for a decrease in treatment to Level A.
 - C. Decreasing an offender's level of intensity of treatment shall only occur at scheduled Treatment Plan Review intervals and shall be approved by consensus of the MTT. This change in treatment level shall include written justification placed in the offender's file describing the need for change in treatment.
 - D. Increasing an offender's level of treatment to a higher intensity of treatment may occur at any time and shall be approved by consensus of the MTT. This change in treatment level shall include written justification placed in the offender's file describing the need for change in treatment.

8.11 Violations of Offender Contract: Violations of Offender Contract or noncompliance with the Treatment Plan may lead to termination from the program. At a minimum, written or verbal notification of the violations shall be provided to the MTT. Notification of the violations on noncompliance will be provided to law enforcement and/or courts, when appropriate. Violations of the Offender Contract may include exhibiting signs of imminent danger to others or escalating behaviors that may lead to violence.

8.12 Treatment Discharge: Refer to *Standard* Section 5.09 - Offender Discharge

8.13 Out-of-State Court Orders: Approved Providers will comply with Section 17-27.1-101 et. seq., C.R.S. Failure to comply may result in legal and monetary penalties pursuant to Section 17-27.1-101(9)(a), C.R.S.

9.0 Provider Qualifications

Due to the nature and seriousness of domestic violence, professionals who work domestic violence offenders require training, competencies, and expertise in domestic violence offender dynamics and victim safety.³⁸ The following section outlines the requirements necessary to become a DVOMB Approved Provider, and to continue practicing as a DVOMB Approved Provider (hereafter Provider).

- I. Pursuant to Section 16-11.8-104, C.R.S., domestic violence offender treatment shall only be provided by a DVOMB Approved Provider. Providers not on the DVOMB Approved Provider List, including any provider who is denied placement or removed from the Provider List, shall not provide any treatment, evaluation, or assessment services pursuant to statute in Colorado to domestic violence offenders. No referral source shall use any provider not on the Provider List, denied placement or removed from the provider list per Section 16-11.8-104, C.R.S.³⁹
- II. All face-to-face sessions with clients must be co-facilitated with a Full Operating Level (FOL) Provider or a Domestic Violence Clinical Supervisor (DVCS), physically present throughout the application process for any level or specific status. This includes all domestic violence services, including but not limited to individual sessions, group sessions, evaluations and any other domestic violence related services governed by these *Standards and Guidelines*.
- III. New applicants who are co-facilitating any domestic violence offender treatment or evaluation services, must have supervision by a DVCS who is registered and in good standing with the Colorado Department of Regulatory Agencies (DORA).
- IV. All training and co-facilitation hours used for the purpose of an application must have been obtained within the past five (5) calendar years.
- V. New Applicant Status - Not Listed on the DVOMB Approved Provider List

New Applicant Status is for individuals who have never applied to become listed as a Provisional Level (PL), Entry Level (EL), or Full-Operating Level (FOL) Provider on the DVOMB Approved Provider List. Individuals working towards meeting the necessary requirements for approval as a PL, EL, or FOL Provider shall submit for the New Applicant Status using the required application. Initial listing at the New Applicant Status is good for one year to allow the provider time to develop competency in the required areas. The application shall be submitted and include a supervision agreement co-signed by their approved DVCS, and submit fingerprints through an approved vendor

³⁸ Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., . . . Solano, I. (2016). Domestic Violence Perpetrator Programs: A Proposal for Evidence-Based Standards in the United States. *Partner Abuse*, 7(4), 355-460. doi:10.1891/1946-6560.7.4.355.
Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. *International Journal of Mental Health Nursing*, 17, 57-64.; Roth, A. D., Pilling, S., & Turner, J. (2010). Therapists training and supervision for clinical practice. *Behavioural and Cognitive Psychotherapy*, 38, 291-302.

³⁹ 16-11.8-104(1) C.R.S. On and after January 1, 2001, the department of corrections, the judicial department, the division of criminal justice within the department of public safety, or the department of human services shall not employ or contract with and shall not allow a domestic violence offender to employ or contract with any individual or entity to provide domestic violence offender treatment evaluation or treatment services pursuant to this article unless the individual or entity appears on the approved list developed pursuant to section 16-11.8-103 (4).

(for purposes of a criminal history record check pursuant to Section 16-11.8-103 (4)(a)(III)(A), C.R.S) prior to beginning work with domestic violence offenders. Once approved, New Applicants may begin accumulating co-facilitation hours and must not provide any domestic violence offender services without co-facilitation.

Discussion Point: Individuals designated as New Applicant Status will not be shown on the Approved Provider List.

VI. Out-of-State Applicants: Individuals who hold professional licensure, domestic violence offender (intimate partner) or batterer intervention licensure, certification or approval, and reside outside Colorado may seek Entry or Full Operating Level status if they meet all of the qualifications listed in the *Standards and Guidelines*. Required supervision hours must have been provided by an individual whose qualifications substantially match those of a DVOMB Approved Clinical Supervisor as defined in these Standards. Out-of-state applications will be reviewed on a case-by-case basis.

VII. Listing Status as an Approved Provider

Applicants may seek approval for six different types of listing status on the DVOMB Approved List.

- **Provisional Level (PL) Provider - Section 9.02**

Provisional Level (PL) is a status designed for communities with a demonstrated need for an Approved Provider. Provisional approval is most often applicable to rural areas and where offender or specific populations needs are underserved or unmet. Provisional approval shall only be for a designated area of the state. Once approved by the DVOMB, PL Providers are not eligible to practice in other areas of the state.

- **Entry Level Provider (EL) - Section 9.03**

Entry Level (EL) Provider is an introductory level status. After receiving approval through the Intent to Apply Application, applicants receive ongoing supervision by an Approved Domestic Violence Clinical Supervisor (DVCS) and can begin working toward approval. EL Applicants may seek a modified approval for either offender treatment only, post-sentence offender evaluation only, or both. Once approved by the DVOMB, EL Providers are required to receive ongoing supervision by an Approved DVCS while providing domestic violence offender services.

- **Full Operating Level Provider (FOL) - Section 9.04**

Full Operating Level (FOL) Provider is a status for those who have met all educational, training, and experiential requirements and no longer require ongoing supervision. Applicants seeking placement for FOL status are not eligible for modified approval for either offender treatment only, post-sentence offender evaluation only. Once approved by the DVOMB, these individuals are expected to be competent and capable of providing both domestic violence post-sentence offender evaluation and offender treatment services independently with the support of a peer consultant. FOL Providers may co-facilitate with PL or EL applicants, but may not supervise PL or EL applicants.

- **Domestic Violence Clinical Supervisor (DVCS) - Section 9.05**

Domestic Violence Clinical Supervisor (DVCS) is a status for licensed FOL Provider who has

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obtained the additional training and experiential requirements for supervisors. Once approved, these individuals may provide supervision to applicants and Providers in accordance with the *Standards and Guidelines*.

- **Specialized Pre-Sentence Evaluator Status - 9.06**

Specialized Pre-Sentence Evaluator is a status for licensed FOL Providers who demonstrate competencies, skills, and knowledge in conducting complex and in-depth offender evaluations prior to sentencing. Once approved by the DVOMB, these individuals may conduct Pre-Sentence Evaluations (PSE) in accordance with the *Standards and Guidelines*.

- **Specific Offender Population Status - 9.07**

Specific Offender Population (SOP) is a status for either female and/or LGBTQIA+ offenders. Once approved by the DVOMB, these individuals may provide domestic violence services to that population.

9.01 General Requirements for All Applicants⁴⁰

Applicants for any listing status shall meet all of the following general criteria:

- A. Hold a baccalaureate degree or above in a behavioral science with, training and experience as a counselor or psychotherapist. The degree must be obtained from a college or university accredited by an agency recognized by the U.S. Department of Education.⁴¹

OR

Hold a CAC-II or CAC-III with a minimum of a baccalaureate degree in any field. The degree must be obtained from a college or university accredited by an agency recognized by the U.S. Department of Education.

- B. Hold a professional mental health license, certification, be listed as a candidate for a mental health license, or registered psychotherapist with the Colorado Department of Regulatory Agencies (DORA), and not be under current disciplinary action that the Application Review Committee (hereafter ARC) determines would impede the applicant's ability to practice as a DVOMB Approved Provider.
- C. Submit to a current background investigation in addition to a state and national criminal history record check pursuant to Section 16-11.8-104(2)(a), C.R.S.

⁴⁰ Spence, C., Cantrell, J., Christie, I., & Samet, W. (2002). A collaborative approach to the implementation of clinical supervision. *Journal of Nursing Management*, 10, 65-74.; 16-11.8-104(2)(a) C.R.S. The board shall require any person who applies for placement, including any person who applies for continued placement, on the approved provider list developed pursuant to section 16-11.8-103 (4) to submit to a current background investigation that goes beyond the scope of the criminal history record check described in section 16-11.8-103 (4) (a) (III) (A). In conducting the current background investigation, the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide domestic violence offender treatment evaluation or treatment services pursuant to this article.

⁴¹ Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., Solano, I. (2016). Domestic Violence Perpetrator Programs: A Proposal for Evidence-Based Standards in the United States. *Partner Abuse*, 7(4), 355-460. doi:10.1891/1946-6560.7.4.355. Cannon, C., Hamel, J., Buttell, F., & Ferreira, R. J. (2016). A survey of domestic violence perpetrator programs in the United States and Canada: Findings and implications for policy intervention. *Partner Abuse*, 7(3), 226-276.

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- D. Demonstrate community collaboration with local non-profit victim services, probation offices, and task forces.
- E. Demonstrate compliance with the DVOMB *Standards and Guidelines* by completing all application requirements which include, but are not limited to, submitting offender services work product, reference letters, and an assessment of competencies.
- F. Shall not have a conviction of, or a deferred judgement (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contendere to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved provider to practice under these *Standards and Guidelines* as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea.
- G. Shall notify the Board of any civil dispute involving an underlying factual basis of domestic violence, in order for the ARC to review and determine the ability of the individual to practice under these *Standards and Guidelines*.
- H. Comply with all other requirements as outlined in the DVOMB Administrative Policies.

9.02 Provisional Level Provider Requirements

Provisional approval is most often applicable to rural areas where the needs of a community are underserved or unmet. The decision to grant provisional approval will be primarily based upon a well-documented community need that demonstrates that certain community needs cannot be met by existing DVOMB Approved Providers. Provisional approval shall only be for a designated area of the state. Provisional approved providers are not eligible to practice in other areas of the state.

Provisional Level is granted at the discretion of the ARC.

- I. Applicants seeking to be listed as a Provisional Level Provider shall demonstrate community need for offender treatment that cannot be met by existing approved providers by obtaining at least five letters of community support documenting and identifying specific community need for offender treatment from victim services, criminal justice supervision agency, and other individuals representing agencies involved in offender containment.
- II. Applicants seeking to be listed as a Provisional Level Provider shall meet the following experiential criteria:
 - A. Possess 300 general experiential counseling hours. These hours shall be face-to-face client contact hours providing evaluations and/or individual and/or group counseling sessions. The applicant must have received a minimum of **15** hours of one-to-one supervision while accruing the **300** hours.
 - B. In addition to the 300 general experiential hours, applicants who hold a master's degree in counseling or higher with a minimum of 1000 hours of counseling experience, shall have accrued **30** face-to-face client contact hours working with domestic violence offenders obtained in no less than a four-month period. These contact hours shall include the co-facilitation of offender evaluations, group sessions, and may include individual treatment

sessions.

III. The Provisional Applicant shall meet the following training hours:

- A. All applicants shall possess a minimum of **35 hours** of documented training comprised of **7** hours of victim safety and victim dynamic subject areas, **14** hours of offender evaluation and assessment, and **14** hours of offender treatment facilitation and treatment planning.⁴²

Domestic Violence Victim Issues - 7 Hours:

- Role of Treatment Victim Advocate in domestic violence offender treatment
- Offender containment and working with a Treatment Victim Advocate
- Crisis intervention
- Legal issues including confidentiality, duty to warn, and orders of protection
- Impact of domestic violence on victims
- Safety planning
- Victim dynamics including obstacles and barriers to leaving abusive relationships
- Trauma issues

Offender Evaluation and Assessment Specific to Domestic Violence - 14 Hours:

- Clinical interviewing skills
- Domestic violence risk assessment
- Substance abuse screening
- Criminal justice cases and the use of collateral sources of information
- Types of abuse
- Domestic violence offender typologies
- Cognitive distortions
- Criminal thinking errors
- Criminogenic needs

Facilitation and Treatment Planning - 14 Hours

- Substance abuse and domestic violence
- Offender self-management
- Motivational interviewing
- Provider role in offender containment
- Forensic psychotherapy
- Coordination with criminal justice system
- Offender accountability
- Recognizing and overcoming offender resistance
- Offender contracts

- Ongoing domestic violence offender assessment: skills and tools
- Offender responsivity to treatment
- Learning Styles
- Personality Disorders

⁴² Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., . . . Solano, I. (2016). Domestic Violence Perpetrator Programs: A Proposal for Evidence-Based Standards in the United States. *Partner Abuse, 7*(4), 355-460. doi:10.1891/1946-6560.7.4.355.

IV. Supervision Requirements for Provisionally Approved Provider or Applicant:

- A. The DVCS shall review and is charged with the responsibility for all clinical work performed by the applicant. In the event that co-facilitation is obtained with a FOL Provider, session notes must be co-signed by that FOL Treatment Provider doing the co-facilitation.
- B. The DVCS shall employ supervision methods aimed at assessing and developing required competencies. It is incumbent upon the supervisor to determine the need for additional training and supervision hours, based upon the supervisee's progress in attaining competency to perform such treatment.⁴³
- C. The minimum amount of hours of face-to-face supervision of domestic violence specific treatment and/or evaluation is calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

- D. The appropriate modality for supervision shall be determined by the DVCS based upon the competencies, training, education, and experience of the supervisee, as well as the treatment setting. Factors that shall be considered are community safety and offender needs, urban versus rural setting, and the availability of resources.
- E. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, audio/videotape, teleconferencing, and Internet). At minimum, the initial supervision meeting must be face-to-face supervision at the beginning of the supervision relationship.
- F. The DVCS shall seek feedback from at a minimum the core MTT members (i.e. treatment provider, criminal justice supervising officer, treatment victim advocate) in order to assist in the assessment of applicant competencies.
- G. Supervision for Provisional Level applicants shall include training on offender evaluation and assessment.

V. Continued Placement for Provisional Level providers.

- A. Continuing education for PL Providers shall consist of the completion of 14 clock hours every year in topic areas relevant to improve the provider competencies in delivering services, and working with domestic violence offenders. The 14 hours shall be comprised of trainings recommended by the DVCS to enhance the PL Provider's competencies including diversity, victim safety, and victim dynamics. Of the 14 hours, the PL Providers shall obtain at least 7 hours on diversity, victim safety, and victim dynamics. PL Providers shall also attend a *Standards Booster and Policy Update* training, in addition to a *DVRNA Booster* training. The

⁴³ Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy*, 49, 373-378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. *International Journal of Mental Health Nursing*, 17, 57-64.

Operating Level approval.

- B. PL Providers shall reapply for continued placement every two years or as determined by the DVOMB. Approval as a PL Provider is valid for two renewal cycles from the initial approval date. PL Providers must apply to EL or FOL Status in order to remain listed on the Provider List.

9.03 Entry Level Provider Requirements

I. Applicants seeking to be listed as an EL Provider shall meet the following experiential criteria:

- A. Possess 300 general experiential counseling hours. These hours shall be face-to-face client contact hours providing evaluations and/or individual and/or group counseling sessions. The applicant must have received a minimum of **15** hours of one-to-one supervision while accruing the **300** hours.

Discussion Point: Applicants with a CAC II or higher or a masters in counseling may demonstrate this with transcripts, licensure or certification.

- B. In addition to the 300 general experiential hours, applicants who hold a master's degree in counseling or higher shall have accrued **54** face-to-face client contact hours working with domestic violence offenders obtained in no less than a four-month period. These contact hours shall include the co-facilitation of offender evaluations, group sessions, and may include individual treatment
- C. In addition to the 300 general experiential hours, applicants who hold a Baccalaureate degree shall have accrued **108** face-to-face domestic violence offender client contact hours in no less than a four-month period. These contact hours shall include the co-facilitation of offender evaluations, group sessions, and may include individual treatment sessions.
- D. Submit documentation of co-facilitation hours from a FOL Provider or a DVCS through a letter of support verifying the face-to-face client contact hours working with domestic violence offenders.
- E. Possess a minimum of 25 face-to-face client contact hours providing clinical substance abuse treatment at an Office of Behavioral Health (OBH) licensed facility or co-facilitated by a CAC II or higher, and supervised by a CAC III or higher.

II. The EL Applicant shall meet all of the following training criteria:

- A. All applicants shall possess a minimum of **42 hours** of documented training comprised of **14** hours of victim safety and victim dynamic subject areas, **14** hours of offender evaluation and assessment, and **14** hours of offender treatment facilitation and treatment planning.⁴⁴
- B. Training areas include the following topics:

⁴⁴ Cannon, C., Hamel, J., Buttell, F., & Ferreira, R. J. (2016). A survey of domestic violence perpetrator programs in the United States and Canada: Findings and implications for policy intervention. *Partner Abuse*, 7(3), 226–276.

Required Core Trainings sponsored by the DVOMB:

- DV100 - DVOMB and Standards Training
- DV101 - DVRNA Training
- DV102 - Offender Evaluation Training
- DV103 - Offender Treatment Training

Domestic Violence Victim Safety and Victim Dynamics - 14 Hours

- Role of victim advocate in domestic violence offender treatment
- Offender containment and working with a victim advocate
- Crisis intervention
- Legal issues including confidentiality, duty to warn, and orders of protection
- Impact of domestic violence on victims
- Victim dynamics to include obstacles and barriers to leaving abusive relationships

Offender Evaluation and Assessment Specific to Domestic Violence - 14 Hours

- DV102 - Offender Evaluation Training
- Clinical interviewing skills
- Domestic violence risk assessment
- Lethality risk assessment
- Substance abuse screening
- The use of collateral sources of information
- Types of abuse
- Domestic violence offender typologies
- Cognitive distortions
- Criminal thinking errors
- Criminogenic needs

Treatment Facilitation and Treatment Planning - 14 Hours

- DV103 - Offender Treatment Training
- Substance abuse and domestic violence
- Offender self-management
- Motivational interviewing
- Provider role in offender containment
- Forensic psychotherapy
- Coordination with criminal justice system
- Offender accountability
- Recognizing and overcoming offender resistance
- Offender contracts
- Ongoing domestic violence offender assessment: skills and tools
- Offender responsivity to treatment
- Learning Styles
- Personality Disorders
- Risk, Needs and Responsivity
- Motivational Interviewing
- Limitations of offender confidentiality

- C. Applicants who hold a Baccalaureate degree shall have a minimum of **35** hours of basic counseling skills training in addition to the 42-hour training requirement. Additional training may be required by DVCS in order to meet minimum criteria in applicant competency levels. Demonstration of these hours does not apply to applicants who hold a Master’s degree *in a counseling related field, or CAC II or higher.*

Basic Counseling Skills - 35 Hours (for baccalaureate degree applicants only)

- Counseling Techniques
- Individual and Group Skills Training
- Treatment Planning
- Group Dynamics

III. Supervision Requirements for **New Applicants Working towards Approval**

- A. The DVCS shall review and co-sign and all session notes, treatment plans, treatment plan review reports, evaluations, and all other reports and documentation by the applicant. The DVCS is responsible for all clinical work performed by the applicant. In the event that co-facilitation is obtained with a FOL Provider, session notes must be co-signed by that FOL Provider doing the co-facilitation.
- B. The DVCS shall ensure that ongoing and regular communication with the FOL Provider is made regarding any co-facilitation hours accumulated for the purpose of assessing an applicant’s competencies.
- C. The DVCS shall employ supervision methods aimed at assessing and developing required competencies. It is incumbent upon the supervisor to determine the need for additional training and supervision hours, based upon that individual’s progress in attaining competency to perform such treatment.⁴⁵
- D. The frequency of face-to-face supervision hours specific to domestic violence specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

- E. The appropriate modality for supervision shall be determined by the DVCS based upon the competencies, training, education, and experience of the supervisee, as well as the treatment setting. Factors that shall be considered are community safety and offender needs, urban versus rural setting, and the availability of resources.
- F. Modes of supervision may include individual or group supervision, direct observation and

⁴⁵ Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy*, 49, 373-378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. *International Journal of Mental Health Nursing*, 17, 57-64.

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electronic (such as telephone, audio, teleconferencing, and Internet). If supervision is conducted via electronic means, face-to-face supervision must be conducted quarterly at a minimum. Face-to-face supervision may be completed through video conferencing. All

communication shall be synchronous.

- G. The DVCS shall seek feedback from at a minimum the core MTT members (i.e. treatment provider, supervising officer, treatment victim advocate) in order to assist in the assessment of applicant competencies.

IV. Supervision Requirements for Entry Level Approved Providers

- A. Licensed and unlicensed EL Providers are required to have clinical supervision for a minimum of two hours per month or more as determined appropriate by a DVCS. One hour shall be individual and one hour may be group supervision.
- B. The appropriate modality for supervision shall be determined by the DVCS based upon the training, workload, education, experience of the supervisee, work towards provider competencies, and the professional judgement of the DVCS. Factors that shall be considered are community safety, and offender needs, urban versus rural setting, and the availability of resources. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, audio/videotape, teleconferencing, and Internet). At minimum, the initial supervision meeting must be face-to-face supervision at the beginning of the supervision relationship. Task force meetings are not an acceptable modality for supervision for EL Providers.

V. Continued Placement for Approved Entry Level Providers.

- A. Continuing Education for EL Providers shall consist of the completion of a minimum of 14 clock hours every year in areas relevant to improve Provider competencies in delivering services, and working with domestic violence offenders. The 14 hours shall be comprised of trainings recommended by the DVCS to enhance the EL Provider's competencies to include diversity, victim safety, and victim dynamics. Every 2 years, the EL Provider shall complete a *DVOMB Standards Booster and Policy Update* training, along with a *DVRNA Booster* training. The EL Provider may apply *DVOMB Standards Booster and Policy Update*, in addition to the *DVRNA Booster* training hours towards total CEU hours for renewal.
- B. EL Providers shall reapply for continued placement every two years or as determined by the DVOMB.

9.04 Full Operating Level Provider Requirements

- I. Applicants seeking to be listed as a FOL Provider shall the following criteria:
 - A. Possess 600 general experiential counseling hours. These hours shall be face-to-face client contact hours providing evaluations and/or individual and/or group counseling sessions. The applicant must have received 50 hours of one-to-one supervision for the 600 hours.

Discussion Point: Applicants with a CAC II or higher or a masters in counseling may demonstrate this with transcripts, licensure or certification.

- B. Applicants who hold a master's degree or higher in a counseling related field shall have **80** hours of face-to-face client contact hours working with domestic violence offenders obtained in no less than a six-month period. The required hours may include domestic violence related co-facilitation of offender evaluations, group sessions, or individual treatment sessions. A minimum of 16 of these experiential hours shall include co-facilitation of offender group sessions.
 - C. Baccalaureate degree applicants shall accumulate **160** hours of face-to-face client contact hours working with domestic violence offenders in no less than a six-month period. The required hours may include domestic violence related co-facilitation of offender evaluations, group sessions, or individual treatment sessions. A minimum of 32 of these experiential hours shall include co-facilitation of offender group sessions.
 - D. The applicant and the co-facilitator of these hours shall spend a minimum of one additional hours per month on clinical preparation and clinical review of these experiential hours.
 - E. Have 50 face-to-face client contact hours providing clinical substance abuse treatment at an Office of Behavioral Health (OBH) licensed facility or co-facilitated by a CAC II or higher, and supervised by a CAC III or higher.
- II. The FOL Applicant shall meet all of the following training criteria:
- A. All applicants shall demonstrate a balanced training history to work towards competencies, as designed and directed by the DVCS.
 - B. Applicants who hold a master's degree shall have a minimum of 50 hours of documented training specifically related to domestic violence evaluation and treatment methods.
 - C. Applicants who hold a Baccalaureate degree shall have a minimum of 100 hours of documented training specifically related to domestic violence evaluation and treatment methods.
 - D. Training areas include the following topics:

Required Core Trainings sponsored by the DVOMB

- DV100 - DVOMB and Standards Training
- DV101 - DVRNA Training
- DV102 - Offender Evaluation Training
- DV103 - Offender Treatment Training

Legal Issues

- Colorado domestic violence and family violence related laws
- Orders of Protection
- Forensic therapy
- Confidentiality and duty to warn in domestic violence cases
- Treatment within the criminal justice system

Domestic Violence Victim Safety and Victim Dynamics

- Role of victim advocate in domestic violence offender treatment

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- Offender containment and working with a victim advocate
- Crisis intervention
- Legal issues including confidentiality, duty to warn, and orders of protection
- Impact of domestic violence on victims
- Victim dynamics to include obstacles and barriers to leaving abusive relationships

Offender Evaluation and Assessment Specific to Domestic Violence

- DV102 - Offender Evaluation Training
- Clinical interviewing skills
- Domestic violence risk assessment
- Lethality risk assessment
- Substance abuse screening
- The use of collateral sources of information
- Types of abuse
- Domestic violence offender typologies
- Cognitive distortions
- Criminal thinking errors
- Criminogenic needs

Treatment Facilitation and Treatment Planning

- DV103 - Offender Treatment Training
- Substance abuse and domestic violence
- Offender self-management
- Motivational interviewing
- Provider role in offender containment
- Forensic psychotherapy
- Coordination with criminal justice system
- Offender accountability
- Recognizing and overcoming offender resistance
- Offender contracts
- Ongoing domestic violence offender assessment: skills and tools
- Offender responsivity to treatment
- Learning Styles
- Personality Disorders
- Risk, Needs and Responsivity
- Motivational Interviewing
- Limitations of offender confidentiality

- E. Applicants who hold a Baccalaureate degree shall have a minimum of **35** hours of basic counseling skills training in addition to the **100** hour training requirement. Additional training may be required by DVCS in order to meet minimum criteria in applicant competency levels. Demonstration of these hours does not apply to applicants who hold a Master's degree *in a counseling related field, or CAC II or higher.*

Basic Counseling Skills - 35 Hours (for baccalaureate degree applicants only)

- Counseling Techniques

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- Individual and Group Skills Training
- Treatment Planning
- Group Dynamics

III. Supervision requirements for **New Applicants Working towards Approval Full Operating Level:**

- A. The DVCS shall review and co-sign and all session notes, treatment plans, treatment plan review reports, evaluations, and all other reports and documentation by the applicant. The DVCS is responsible for all clinical work performed by the applicant.
- B. The DVCS shall employ supervision methods aimed at assessing and developing required competencies. It is incumbent upon the supervisor to determine the need for additional training and supervision hours, based upon that individual's progress in attaining competency to perform such treatment.⁴⁶
- C. The frequency of face-to-face supervision hours specific to domestic violence specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

- D. The appropriate modality for supervision shall be determined by the DVCS based upon the training, workload, education, experience of the supervisee, work towards Provider competencies, and the professional judgement of the DVCS. Factors that shall be considered are community safety, and offender needs, urban versus rural setting, and the availability of resources. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, audio/videotape, teleconferencing, and Internet). At minimum, the initial supervision meeting must be face-to-face supervision at the beginning of the supervision relationship.
- E. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, audio, teleconferencing, and Internet). If supervision is conducted via electronic means, face-to-face supervision must be conducted quarterly at a minimum. Face-to-face supervision may be completed through video conferencing. All communication shall be synchronous.
- F. The DVCS shall seek feedback from at a minimum the core MTT members (i.e. treatment, supervising officer, treatment victim advocate) in order to assist in the assessment of applicant competencies.

IV. Peer Consultation requirements for **Full Operating Level Providers:**

⁴⁶ Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy*, 49, 373-378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. *International Journal of Mental Health Nursing*, 17, 57-64.

- A. All Approved FOL Providers, licensed and unlicensed, are required to have peer consultation with another approved FOL Provider, or a DVCS for a minimum of one hour per month. The peer consultant must also be approved in all specific populations that the FOL Provider is approved. Local task force meetings shall not count toward the monthly peer consultation requirement.

V. Continued Placement for Full Operating Level Providers

- A. Continuing Education for FOL Providers shall consist of the completion of 20 clock hours every two years in areas relevant to improve Provider competencies in delivering treatment and evaluation services with domestic violence offenders. Of the 20 hours, diversity, victim safety, and victim dynamics shall be included. In addition, the FOL Provider shall complete the DVOMB Standards Booster and Policy Update training and DVOMB DVRNA Booster training every two years. The FOL Provider may apply DVOMB *Standards Booster and Policy Update*, in addition to *DVRNA Booster* training hours towards total CEU hours for renewal.
- B. FOL Providers shall reapply for continued placement every two years or as determined by the DVOMB.

9.05 Domestic Violence Clinical Supervisor Requirements

- I. Clinical Supervisors may only provide supervision in the areas they are currently approved. Applicants seeking to be listed as a DVCS shall meet the following criteria:
 - A. Meet all FOL Approved Provider requirements per Section 9.04.
 - B. Hold licensure or certification as a Psychiatrist, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Clinical Psychiatric Nurse Specialist or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicant's ability to practice as a DVCS.
 - C. 49 hours of training specific to substance abuse and addiction.
 - D. 21 hours of training in clinical supervision.
 - E. 75 hours of face-to-face client contact working with domestic violence offenders with a minimum of two (2) years of domestic violence treatment provision at the FOL.
 - F. 100 hours of providing general clinical supervision during the past five (5) years.
 - G. Attest to having knowledge of the DVOMB application requirements pertaining to responsibilities of DVCSs. DVOMB Approved Provider or applicant shall not represent themselves as a DVCS until approval by the DVOMB has been granted.

II. Supervision requirements for Domestic Violence Clinical Supervisor Level Applicants

Prior to the commencement of supervision, the applicant shall receive an initial assessment by an Approved DVCS to determine if the applicant meets the minimum requirements and competencies of 9.04. The initial supervision meeting must be in-person, face-to-face supervision at the beginning of the supervision relationship. Applicants who are assessed by the Approved DVCS as competent shall submit an Intent to Apply.

III. Domestic Violence Clinical Supervision Apprenticeship

- A. Applicants who have an Approved Intent to Apply application as a DVCS may provide supervision to DVOMB applicants with the oversight of an Approved DVCS. The Approved DVCS shall review and is charged with the responsibility of all clinical supervision work performed by the applicant.
- B. The Approved DVCS shall employ supervision methods aimed at assessing and developing required competencies. It is incumbent upon the supervisor to determine the need for additional training and supervision hours, based upon that individual's progress in attaining competency to perform such treatment.⁴⁷

Discussion Point: Best practice supervisory methods should be utilized when possible and appropriate to maximize the learning and skill-based development of applicants. Some examples include but are not limited to etc.

- C. The frequency of face-to-face supervision hours specific to the supervision of domestic violence services will be determined by the Approved DVCS.
- D. The appropriate modality for supervision shall be determined by the Approved DVCS based upon the competencies, training, education, and experience of the supervisee, as well as the treatment setting. Factors that shall be considered are community safety and offender needs, urban versus rural setting, and the availability of resources.
- E. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, audio/videotape, teleconferencing, and Internet). At minimum, the initial supervision meeting must be face-to-face supervision at the beginning of the supervision relationship.
- F. The DVCS shall seek feedback from at a minimum the core MTT members (i.e. treatment provider, supervising officer, treatment victim advocate) in order to assist in the assessment of applicant competencies.
- G. Upon application, the applicant shall submit competency ratings from his/her Approved DVCS using the "Competency Based Assessment for Approval as a DVOMB Clinical Supervisor", including a letter of recommendation and narrative that addresses the following:

⁴⁷ Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy*, 49, 373-378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. *International Journal of Mental Health Nursing*, 17, 57-64.

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- a. How the applicant has stayed current on the literature/research in the field (e.g. attend conferences, trainings, journals, books, etc.)
- b. Research that can be cited to support the applicant's philosophy/framework.
- c. How evolving research/literature has changed the applicants practice.
- d. How supervision content/process has been impacted in response to emerging research/literature in the field.

H. The applicant must maintain listing in the areas he/she are providing supervision and must maintain compliance with the applicable Standards of his/her listing.

IV. Peer Consultation Requirements:

- A. DVCSs shall have a minimum of one hour of peer consultation per month with other Approved Providers who are also licensed. This peer consultation shall be documented as to time, date, and who attended. Group supervision and formal 1:1 supervision hours may also apply toward this requirement. Local task force meetings shall not count toward the monthly peer consultation requirement.
- B. For rural areas peer consultation may include electronic modes of consultation (such as telephone, audio/videotape, teleconferencing, and Internet). At minimum, the initial supervision meeting must be face-to-face supervision at the beginning of the supervision relationship.

V. Continued Placement for DVCS

- A. Continuing Education for DVCS shall consist of the completion of 20 hours every two (2) years in topic areas relevant to improved treatment with domestic violence offenders, and improved supervision with applicants and Approved Providers. Of the 20 hours, diversity, victim safety, and victim dynamics shall be included. In addition, the DVCS shall complete the *DVOMB Standards Booster and Policy Update* training and a *DVRNA Booster* training every two years.
- B. All DVCSs shall reapply for continued placement every two years or as determined by the Board.

VI. Content of Clinical Supervision and Peer Consultation

- A. Supervision and peer consultation shall include, but not be limited to, these areas:
 1. Discussion and review of documentation of case coordination with victim and victim advocate.
 2. Discussion and review of documentation of services provided by the supervisee
 3. Discussion and review of documentation of treatment plans, intervention strategies, and evaluations of offender's progress
 4. Administrative procedures of the practice as they relate to clinical issues
 5. Discussion and follow up of ethical issues
 6. Evaluation of supervisory process, including performance of the supervisor and supervisee
 7. Coordination of services among other professionals involved in particular cases, such as probation, criminal justice, and victim service agencies
 8. *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Domestic Violence Offenders* Relevant Colorado laws and rules and

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regulations, including confidentiality and duty to warn

9. Discussion of offender resistance, transference, and counter-transference issues
10. Continuously assessing supervisee competencies, and making appropriate recommendations regarding additional supervision and training

Discussion Point: The Treatment Victim Advocate shall be included as part of supervision or staffing for applicants and Approved Providers at least quarterly.

VII. Content of Domestic Violence Clinical Supervision Contract

Development of DV Clinical Supervision Contract

The DV Clinical Supervision Contract is the signed supervision agreement between the Applicant/Trainee and DV Clinical Supervisor. Supervision contract must be signed prior to any co-facilitation hours being accrued, and must be signed before any co-facilitation hours may be valid.

A. Supervisor Agreements:

1. Supervisor will review Counselor's work with clients through Counselor's verbal reports and written case records.
2. Supervisor will assist Counselor with questions of ethics and law, transference, counter transference, critical situations including suicidality and homicidally, and counselor self-care, amongst other topics.
3. Supervisor will review all application documents and will assist applicant with the application process.
4. Supervisor agrees to identify areas of improvement of the supervisee, and will refer to appropriate training.
5. Supervisor agrees to be available during business hours for consultation/emergency questions.
6. Supervisor agrees to review, critique, provide guidance and sign all documentation produced supervisee. (If co-facilitator is not DVCS, then FOL co-facilitator will sign off on group and/or evaluation documentation. DVCS must also sign off on evaluations after review).
7. Supervisor agrees to assist supervisee throughout the application process.
8. Supervisor agrees to document and provide all completed hours to the applicant, regardless of final outcome of supervision.
9. Supervisor agrees to maintain professional license, certification and/or approvals and liability insurance, and to promptly inform Supervisee of any development that could disqualify Supervisor from carrying out professional roles.
10. Supervisor agrees to inform Supervisee of any legal or legislative matters that come to attention that may affect the supervision or the Supervisees progress towards DVOMB approval.
11. Supervisor agrees to maintain information provided by Supervisee confidential. Supervisor will not disclose to anyone (with exception to agencies listed below in this contract), any information discussed in sessions, or with the Supervisor's peer consultant. Standard exceptions to confidentiality apply, such as when child abuse, threat to self or others is suspected.
12. Supervisor agrees to address any practice found to be outside of the *Standards and Guidelines* with Supervisee and immediately correct.

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13. Supervisor will inform the DVOMB of termination of supervision agreement within one calendar week.
14. If it is agreed upon that the Supervisee is to provide coverage by utilizing the treatment coverage document provisions, the Supervisor agrees to perform appropriate supervision regarding the coverage, including the population being covered.

B. Supervisee Agreements:

1. If supervisee becomes obtains legal charges of any kind, he/she agrees to report legal charges to supervisor within a 24-hour period.
2. Supervisee agrees to follow all *Standards and Guidelines*, including Administrative Standards.
3. Supervisee agrees to only provide co-facilitated domestic violence treatment. All domestic violence related services (intake/evaluation, individual and group education and treatment) must be co-facilitated with a FOL Provider or a DVCS. At no time prior to DVOMB approval, will the supervisee provide ANY domestic violence related services independently.
4. Supervisee agrees to read the DVOMB Standards and Guidelines, in its entirety, and to always conduct domestic violence offender services within the boundaries of the *Standards and Guidelines*.
5. Supervisee agrees to maintain a current counseling related listing with the Department of Regulatory Agencies, and to inform supervisor of any lapse or complaint within 24 hours.
6. Supervisee agrees to maintain compliance with all licensing, certification and approval agencies (DVOMB, SOMB, OBH, etc).
7. Supervisee will provide proof of DORA registrations.
10. Supervisee agrees to enroll and take any training recommended by Supervisor.
11. Supervisee understand that supervision is NOT psychotherapy. If personal issues arise during the clinical supervision relationship, Supervisee agrees to seek their own psychotherapy in order to resolve issues.
12. The Supervisee is required to follow Colorado State law regarding informed consent to clients.
13. The Supervisee will contact his/her Clinical Supervisor IMMEDIATELY to inform her if a complaint, lawsuit, grievance or sanction is filed against him/her in Colorado or any other state/jurisdiction.
14. By entering into a DV Clinical supervision agreement, the Supervisee provides consent for the Supervisor to communicate with the DVOMB.
15. By entering into a DV Clinical supervision agreement, the Supervisee provides consent for the Supervisor to communicate with the identified Treatment Victim Advocate.
16. The supervisee agrees to allow communication between DVCS and FOL Provider if co-facilitation is taking place with FOL.

9.06 Specialized Pre-Sentence Evaluator Application Requirements for Approval Status

Applicant seeking an additional listed designation as a Specialized Pre-Sentence Evaluator shall meet all of the following criteria along with the FOL Provider requirements per Section 9.04:

- A. Hold a professional mental health license from the Colorado Department of Regulatory Agencies (DORA), and not be under current disciplinary action that the ARC determines would impede the applicant's ability to practice as a DVOMB Approved Provider. Certifications and candidacies do not meet the requirement.
- B. Possess a minimum of 21 hours of training specific to advanced evaluation strategies,

techniques, procedures for conducting forensic evaluations obtained within the past five (5) calendar years.

- D. Possess a minimum of 50 experiential hours conducting domestic violence pre-sentence offender evaluations.
- E. Demonstrate competency according to the applicant's respective professional standards and ethics consistent with the accepted standards of practice of domestic violence offender evaluations.
- E. Assessed as competent of the DVOMB Evaluator Competencies by a DVCS who is also approved as a Specialized Pre-Sentence Evaluator.

9.07 Specific Offender Populations⁴⁸

In order to provide services to Specific Offender Populations (SOP) identified by the DVOMB, the Approved Provider shall obtain the corresponding specific approval status to provide domestic violence services to that population. There are currently two specific offender populations that require approval by the DVOMB before domestic violence offender services (e.g., evaluation, treatment, advocacy) can be provided: female offenders and LGBTQIA+ offenders.

I. Requirements for Applicants Working towards SOP Approval:

A. Specific Offender Population applicants shall meet the following:

1. **Experiential criteria:** The applicant shall have 50 face-to-face general client contact hours with that specific population. Based on the assessment of competencies by the SOP DVCS of the applicant, these hours can be demonstrated with services to justice involved and non-justice involved domestic violence populations including other mental health or substance abuse services obtained under a valid DORA registration. All face-to-face hours acquired with domestic violence offenders shall be obtained by co-facilitating with an Approved Provider who is approved with that specific population, who is FOL or DVCS level.
2. **Training hours:** The applicant shall have a minimum of 14 hours of SOP domestic violence offender training. In order to meet all required competencies, the DVCS may require additional training in areas where the applicant may need growth and improvement. SOP training hours may also be

utilized in new or additional applications, in appropriate training categories.
3. **Competencies:** The DVCS shall assess the applicant on the Specific Offender Population Provider competencies.
4. **Supervision:**
 - a. The applicant must work under a DVCS who is approved to work with the Specific Offender Population (referred to as the SOP DVCS) while completing the application

⁴⁸ A Specific Offender Population is defined as a group of individuals that share one or more common characteristics such as race, religion, ethnicity, language, gender, age, culture, sexual orientation and/or gender identity that would allow for the group to be considered culturally sensitive to the offender.

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- b. The DVCS shall seek feedback from at a minimum the core MTT members (i.e. treatment provider, criminal justice supervising officer, treatment victim advocate) in order to assist in the assessment of applicant SOP competencies.
- c. The appropriate modality for supervision shall be determined by the DVCS based upon the competencies, training, education, and experience of the supervisee, as well as the treatment setting. Factors that shall be considered are community safety and offender needs, urban versus rural setting, and the availability of resources.
- d. Specific Offender Population Domestic Violence Clinical Supervision hours may be in conjunction with supervision hour requirements of the Approved Provider or Applicant's DV supervision hours.
- e. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, audio/videotape, teleconferencing, and Internet). At minimum, the initial supervision meeting must be face-to-face supervision at the beginning of the supervision relationship. Task force meetings are not an acceptable modality for supervision for SOP supervision or peer consultation.

II. Requirements for Approved SOP Provider:

A. Continued Supervision Requirements for **SOP Approved Providers**:

1. Based on the level of approval, licensed and unlicensed Approved SOP Provider are required to have:
 - a. DV Clinical Supervision commensurate to the requirements for current Level of Approval, (e.g. Provisional, Entry). The DV Clinical Supervisor must also hold the same SOP approval.
 - b. Peer Consultation commensurate to the requirements for current Level of Approval, (e.g. FOL, DVCS). The Peer Consultant must also hold the same SOP approval.
2. SOP supervision or peer consultation, shall be conducted following Standards Section 9.07, I, A, 4, b-e.

B. Continued Placement for Approved Specific Offender Population Approved Providers:

1. All Approved Providers shall reapply for continued placement every two years or as determined by the Board.
2. SOP approved Providers must complete a portion of their continuing education to include topics on the SOP approved in.

Note: Research cited in this document speaks to the benefits of clinical supervision, therapist training, and therapist competencies but does not specifically dictate the necessity of these.

Reference Guided for Baccalaureate Degree Applicants

Minimum Hours Required by Category	Provisional Level Section 9.02	Entry Level Section 9.03	Full Operating Level Section 9.04								
General Experiential Counseling Hours	N/A	300 Hours a minimum of 15 hours of one-to-one supervision	600 Hours a minimum of 50 hours of one-to-one supervision								
Co-Facilitated Domestic Violence Experiential Hours	N/A	108 Hours	160 Hours								
Substance Abuse Treatment Experiential Hours	N/A	25 Hours	50 Hours								
Training Hours	N/A	42 Hours + 35 Hours of Basic Counseling Skills	100 Hours + 35 Hours of Basic Counseling Skills								
Clinical Supervision Hours	Tiered based on the number of direct clinical contact hours. <table border="0" style="width: 100%; text-align: center;"> <tr> <td style="width: 50%;">Direct Clinical Contact Hours per Month</td> <td style="width: 50%;">Minimum Supervision Hours per Month</td> </tr> <tr> <td>0-59</td> <td>2</td> </tr> <tr> <td>60-79</td> <td>3</td> </tr> <tr> <td>80 or more</td> <td>4</td> </tr> </table>			Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month	0-59	2	60-79	3	80 or more	4
Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month										
0-59	2										
60-79	3										
80 or more	4										
Continuing Education	N/A	14 Hours per renewal year*	20 Hours*								
Maximum Number of Renewal Periods	N/A	Unlimited	Unlimited								

Reference Guided for Master's Degree Applicants

Requirements by Category	Provisional Level Section 9.02	Entry Level Section 9.03	Full Operating Level Section 9.04								
General Experiential Counseling Hours	300 Hours a minimum of 15 hours of one-to-one supervision	300 Hours a minimum of 15 hours of one-to-one supervision	600 Hours a minimum of 50 hours of one-to-one supervision								
Co-Facilitated Domestic Violence Experiential Hours	30 Hours	54 Hours	80 Hours								
Substance Abuse Treatment Experiential Hours	N/A	25 Hours	50 Hours								
Training Hours	35 Hours	42 Hours	50 Hours								
Clinical Supervision Hours	Tiered based on the number of direct clinical contact hours. <table border="0" style="width: 100%; text-align: center;"> <tr> <td style="width: 50%;">Direct Clinical Contact Hours per Month</td> <td style="width: 50%;">Minimum Supervision Hours per Month</td> </tr> <tr> <td>0-59</td> <td>2</td> </tr> <tr> <td>60-79</td> <td>3</td> </tr> <tr> <td>80 or more</td> <td>4</td> </tr> </table>			Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month	0-59	2	60-79	3	80 or more	4
Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month										
0-59	2										
60-79	3										
80 or more	4										
Continuing Education	14 Hours per renewal year*	14 Hours per renewal year*	20 Hours*								
Maximum Number of Renewal Periods	2 Renewal Periods	Unlimited	Unlimited								

* As part of CEU's, Approved Providers must complete a DVOMB Standards Booster and Policy Update training, along with a DVRNA Booster training, every renewal cycle.

10.0 Administrative Standards

10.01 Violence Free: Approved Providers shall be violence-free in their own lives.

10.02 Criminal Convictions:

a) Approved Providers shall not have a conviction of a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contendere to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability of the approved provider to practice under these Standards. A certified copy of the judgment from a court of competent jurisdiction of such conviction or plea shall be conclusive evidence of such conviction or plea.

Discussion Point: An applicant may submit a letter requesting feedback from the Application Review Committee regarding his/her criminal history prior to submitting an application and receive feedback regarding whether that criminal history may prevent him/her from being approved as a treatment provider.

b) Approved Providers shall not engage in criminal activity.

10.03 Respect and Non-discrimination: Approved Providers shall communicate and be respectful of the uniqueness of all people. An Approved Provider shall not practice, condone, facilitate, or collaborate with any form of discrimination.

10.04 Substance Abuse: Approved Providers shall not abuse drugs or alcohol.

10.05 Offender Fees: The offender paying for his/her own evaluation and treatment is an indicator of responsibility and shall be incorporated in the treatment plan. All Approved Providers shall offer domestic violence offender evaluation and treatment services based on a sliding scale fee. (See Glossary of Terms - Appendix C)

10.06 Offender Records: All Approved Providers shall have written documentation of the offender's evaluation information, treatment plan, treatment plan reviews, offender contract, case notes, offender's observed progress, attendance, payment of fees, collateral contacts and records, record of referrals, violations of offender contract, monthly reports to Probation, and discharge summary. In addition, Approved Providers working with domestic violence offenders shall meet record keeping standards outlined by their professional groups. Questions regarding professional record retention shall be directed to the Department of Regulatory Agencies.

10.07 Confidentiality: An Approved Provider shall not disclose confidential communications in accordance with Section 12-43-218, C.R.S.

10.08 Release of Information: When enrolling a client in treatment, a provider shall obtain certain signed releases of confidentiality based on the informed consent of the client. The information shall be provided in a manner that is easily understood, verbally and in writing, in the native language of the person, or through other modes of communication as may be necessary to enhance understanding. A provider shall obtain the following releases, which should each be completed as a separate document with its own signature from the client:

a) Required Treatment Release: This release shall explain that written and verbal information will be shared between the following individuals: victim(s) of record, all members of the MTT and

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shall, if applicable, extend to the Department of Human Services, or other individuals or agencies responsible for the supervision of the client. Other releases of confidentiality may include the offender's former partner(s), current and/or past therapist or Approved Provider, and where warranted, any guardian ad litem, or other professionals working on behalf of the adult and child victims of the offender. The provider shall document any exceptions to this Standard.

- b) **Required Adjunct Treatment or Intervention Release:** For clients recommended and planned to undergo a required adjunct treatment or intervention to address a co-occurring issue as a second contact in addition to domestic violence offender treatment, this release shall comply with all state and federal regulations.
- c) **Required Substance Use Disorder Treatment Release:** For clients undergoing substance use disorder treatment co-occurring with domestic violence offender treatment, this release shall comply with the provisions of 42 C.F.R. § 2.31.
- d) **Research Release:** A provider shall present this release for voluntary informed consent by the client. The client may agree to a release of confidentiality for information to be shared with the Board for the purpose of research related to the evaluation or implementation of the Standards and Guidelines for domestic violence offender management in Colorado, in compliance with 45 CFR § 164.508.

Discussion Point: The research release is voluntary and should be presented for the client's review and determination for voluntary informed consent. All other releases are required for domestic violence offender treatment.

10.09 Duty to Warn: Approved Providers have the duty to warn as defined in Section 13-21- 117, C.R.S. If the offender shows signs of imminent danger or escalated behaviors that may lead to violence, the Approved Provider shall:

- a) Contact the victim or person to whom the threat is directed and victim services, if appropriate;
- b) Notify law enforcement when appropriate;
- c) Contact the responsible criminal justice agency to discuss appropriate responses. The response shall include, but is not limited to, an assessment by the MTT of the current treatment and a decision whether the changes to treatment are appropriate based on the increased containment needs of the offender.

10.10 Duty to Warn: Approved Providers are required by law to report child abuse and/or neglect according to statute Section 19-3-304, C.R.S.

10.11 Offenses Involving Unlawful Sexual Behavior: When there is a conviction for an offense for which the underlying factual basis has been found by the court on the record to include an act of domestic violence, and the conviction includes a sex offense as defined in Section 16-11.7- 102 (3), C.R.S. or an offense which the court finds on the record to include an underlying factual basis of a sex offense, then that offender shall be evaluated and treated according to the Colorado Sex Offender Management Board Standards and Guidelines For The Assessment, Evaluation, Treatment And Behavioral Monitoring Of Adult Sex Offenders.

10.12 Treatment Data: Approved Providers shall participate in, and cooperate with, Board research projects related to evaluation or implementation of the Standards or domestic violence offender management in Colorado in accordance with Section 16-11.8-103(4)(b)(IV), C.R.S.

10.13 Approved Provider Contact Information: Approved Providers are responsible for notifying the Board in writing of any changes in provider name, address, phone number, program name, Treatment Victim Advocate, Domestic Violence Clinical Supervisor or Peer Consultant and any additional Treatment locations, no later than 2 weeks after any change.

- 10.14 Approved Provider Audit:** The Board may audit an Approved Provider for compliance with *Standards and Guidelines* when necessary. The audit may include: site reviews of implementation of administrative and program policies and procedures, staff interviews, case file reviews, program observation and community interviews, and/or requests for comments.
- 10.15 Grievances:** Any victim, offender or community member that has concerns or questions regarding an Approved Provider or their treatment practices may contact the Board. Grievances and complaints must be submitted in writing to the Board or the Department of Regulatory Agencies (DORA). All grievances and complaints received by the Board will be forwarded to DORA and handled by the appropriate DORA board.
- 10.16 Violations of Standards:** Violations of these *Standards and Guidelines* may be grounds for action by the Board pursuant to Section 16-11.8-103, C.R.S.
- 10.17 Variances:** An Approved Provider may request a variance to the *Standards and Guidelines* that shall be subject to the approval by the Application Review Committee. Variances may pertain to economic hardship or victim advocacy and most often are applicable to rural area.

11.0 Appendices

11.0 Appendices

Appendix A: DVOMB Statement Regarding the Evaluation and Treatment of Non-Justice Involved Domestic Violence Offenders

Appendix B: Overview For Working With Specific Offender Population Best Practice Guidelines

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Appendix A:

DVOMB Statement Regarding the Evaluation and Treatment of Non-Justice Involved Domestic Violence Offenders

Adopted September 9, 2011

The DVOMB understands that Approved DV Treatment Providers are sometimes presented with persons seeking DV evaluation and treatment who have not been charged with or convicted of DV offenses. Such evaluation and treatment is outside of the statutory mandate of the DVOMB and therefore not directly subject to the DVOMB *Standards and Guidelines*. The DVOMB is not opposed to Approved DV Treatment Providers providing evaluation and treatment to such persons, using the providers professional and ethical judgment appropriately, and using the DVOMB *Standards and Guidelines* as the provider deems appropriate.

Appendix B:

Overview for Working with Specific Offender Populations

The Board recognizes that domestic violence offender treatment is a developing specialized field. The *Standards and Guidelines* are based on the best practices known to date for the management and treatment of domestic violence offenders.

There is a growing awareness of the importance of designing and implementing specific treatment programs sensitive to diverse populations. *The Standards and Guidelines do not specifically* reflect awareness or sensitivity to differences within specific offender populations. *These appendices are intended to supplement the Standards and Guidelines in these areas.* The Board is committed to modifying and adapting treatment techniques, standards, and principles for those specific offender populations that are represented in the state of Colorado.

All of the guidelines for working with specific offender populations will follow the same general format that includes the following content areas:

- Competency, training and experience requirements for providers
- Assessment of offenders
- Treatment parameters and dynamics
- Curriculum of unique topic areas
- Supervision/consultation issues
- Victim advocacy
- Resources
- Bibliography
- Definitions

The Board will remain current on the emerging literature and research and will modify the documents included in this appendix *as needed*. Because literature and research are evolving in nature, this appendix is a work in progress.

The governing philosophy of public *and community* safety and protection of victims will guide the Board in the development of the criteria for working with specific offender populations.

Appendix B: Specific Offender Population Best Practice Guidelines

I. For Providing Offender Treatment to Domestic Violence Offenders in Same-Sex Relationships

On June 9, 2006 the Domestic Violence Offender Management Board (DVOMB) formally adopted these Guidelines. The following Guidelines have been developed to address the unique aspects of treatment with individuals who have used violence against a same-sex partner. These Guidelines may be relevant to individuals who identify as gay, lesbian, bisexual, transgender, intersex, pansexual, questioning, or queer (see I. Definitions). While domestic violence research and treatment with some “sexual minorities” (i.e., transgender, intersex, pansexual individuals) is limited, the experience of marginalization and oppression crosses all of these orientations and identities. Not only must the Treatment Provider demonstrate skill in addressing issues of violence in same-sex relationships (regardless of how the offender identifies: i.e., a “straight” identified male offender in a relationship with a male), the Provider must also recognize issues related to sexual orientation and identity. These Guidelines supplement the DVOMB *Standards and Guidelines* and are found in the Appendix of the Standards.

A Specific Offender Population Subcommittee of the DVOMB was established to develop these Guidelines. The Subcommittee, comprised of state and local experts in the field of same-sex partner abuse (including treatment providers, victim service providers and advocates, probation/corrections officers, and others involved in the criminal justice system) collaborated in the creation of these Guidelines. Clinical and professional expertise, as well as a review of available research and literature, served as the foundation for these Guidelines.

The treatment issues unique to offenders in same-sex relationships require that providers working with this population have specific experience, knowledge, and assessment skills to effectively assess for and provide treatment to offenders. The following describes training, assessment, treatment, and supervision issues related to effective work with same-sex offenders.

The issues identified here should be integrated throughout treatment, rather than approached as separate from the core of the treatment curriculum.

A. Competency, training and experience requirements for providers

1. Minimum competencies-obtained through core or basic trainings (10.03 Training Hours)
 - Basic definitions/terminology: lesbian, gay, bisexual, transgender, queer (LGBTQ). See I. Definitions
 - Homophobia/heterosexism
 - Sexual orientation vs. Gender identity Stages of coming-out process (e.g., Cass, Coleman, La Pierre; see H. Bibliography)
 - Role of sex in relationships
 - Gender stereotypes
 - Same-sex relationship violence: power and control wheel
 - LGBTQ outing

- LGBTQ hate crimes
- System discrimination: police, courts, treatment
- Societal marginalization: family, church, housing, employment
- Probable cause arrest laws/policies/procedures
- Dual arrest: predominant aggressor vs. co-combatant vs. true victim
- Familiarity with community resources for LGBTQ victims or offenders

2. Critical training areas - obtained through advanced trainings (See G. Resources and I. Bibliography)

- a. Internalized homophobia/heterosexism
- b. Stages of same-sex relationship development
- c. Role models in LGBTQ communities
- d. Healthy relationship dynamics and/or processes
- e. Parenting: adoption, foster, birth, co-parenting

3. Field experience requirements (10.04 Experiential Hours)

B. Assessment of offenders

1. Unique aspects of violence history (e.g., vulnerability to hate crimes)
2. Prior arrest and conviction history, including background check, criminal involvement related to partner. Prior criminal cases in which the offender was the identified victim.
3. Unique aspects of relationship history (e.g., more extensive than standard; relationship agreement regarding monogamy)
 1. Unique aspects of drug/alcohol addiction and recovery. Addiction history: drug/alcohol evaluations (SSI, ASI, ASAM and/or DSM); “meth rage”; criminal activities related to addiction.
 2. Unique sexual activity history
 3. Gender stereotypes in relationship(s)
 4. Unique health issues (e.g., HIV, cancer, hepatitis, STD)
 5. Current offense/arrest information: level of aggression (predominant aggressor vs. co-combatant vs. true victim)
 6. Level of internalized homophobia
 7. Stage of LGBTQ socialization
 8. Stage of coming out
 9. Level of acceptance/rejection: family, friends, employer, landlord
 10. Level of access to LGBTQ support resources
 11. Unique stalking concerns
 12. Relationship assessment
 - Current status of relationship
 - Mutuality assessment: Are both partners abusive? Only the defendant? Or only the “victim”? Stalking, harassment, potential violence by current partner
 - Lethality assessment as appropriate
 - Prior violence: Was the defendant in other abusive relationships as either offender or victim?
1. Anger assessment: behaviors when angry; “triggers” for anger; emotional volatility
2. Rape, sexual abuse history, childhood history of victimization
3. Current offense/arrest information: level of aggression (predominant aggressor vs. co-combatant vs. true victim)
4. Self-defending victims

C. Treatment parameters and dynamics (10.08 Sexual Orientation)

1. Same-sex offender groups: benefits, challenges, boundaries, structure
2. Resistance
3. Uniqueness and Isolation
4. Unique methods of victimization: victim outing; victim invisibility; victim degenderization
5. Impact of uniqueness of community: limited confidentiality; current friends vs. future partners
6. Completion/Discharge
 - Unique aspects of accountability
 - Unique aspects of consistent use of time-outs
 - Higher expectation of more open and honest communication with victim
 - Less stereotypical roles in relationship
 - Less controlling social behavior
7. Unique safety issues

D. Curriculum of unique topic areas working with same-sex relationship offenders (10.06 Offender Treatment Goals)

1. The LGBTQ topic areas addressed here should be integrated throughout treatment, rather than approached as separate from the core of the treatment curriculum
2. Stages of LGBTQ coming-out process
3. Stages of LGBTQ relationship development
4. Role models in communities
5. Role of sex in relationships
6. Gender stereotypes
7. Homophobia/heterosexism
8. Outing
9. Hate crimes
10. System marginalization
11. System discrimination

E. Supervision/consultation issues (10.05 Supervision)

The supervisor/consultant should have expertise in working with both offenders and victims and have the adequate training in both areas

F. Victim advocacy (7.03 b)

1. Unique advocacy considerations; e.g., “partner outreach”
2. Training recommendations
 - a. Basic LGBTQ definitions/terminology
 - b. Awareness of unique techniques of abuse (e.g., internalized homophobia, outing, medical status, stigmatization or isolation of victim)
 - c. Unique safety concerns (e.g., minimization, lack of safehouses)
3. Resources: CAVP, Q center, private therapists, support groups

G. Resources

1. Community-based LGBTQ Relationship Violence Resources (e.g., Colorado Anti-Violence Program)
2. LGBTQ Centers
3. LGBTQ -skilled therapists
4. DVOMB/SOP approved treatment providers
5. DVOMB/SOP trainings

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I. Definitions

Throughout this document, the acronym “LGBTQ” is used to refer to “GLBTQ” and “GLBTIQA” as defined below.

1. **GLBTQ & GLBTIQA:** These letters are used as shorthand for the gay, lesbian, bisexual, transgender, questioning and allied community. “I” for intersex and “A” for ally are often included in this “alphabet soup.”
2. **Gay:** The word gay is generally used to describe men who are romantically and sexually attracted to other men. It is sometimes used to refer to the general GLBTQ community, but most often refers to just gay men. There are many other terms used to refer to gay men, but much of the time they are derogatory, offensive and often painful and should not be used (i.e. fag, etc.).
3. **Lesbian:** The word lesbian is generally used to describe women who are romantically and sexually attracted to other women. This term originates with the female poet Sappho who lived in a community comprised predominantly of women on the Isle of Lesbos in ancient Greece. There are many other terms used to describe lesbians, but much of the time they are derogatory, offensive and often painful and should not be used (i.e. dyke, etc.).
4. **Bisexual:** The term bisexual is generally used to describe people who are romantically and/or sexually attracted to people of more than one sex or gender.
5. **Sex & Gender:** It is easy to confuse these two concepts and terms; however, they are different. Sex refers to the biological sex of a person. Gender refers to their societal appearance, mannerisms, and roles.
6. **Transgender:** The word transgender is an umbrella term used to refer to people who transcend the traditional concept of gender. Many feel as though they are neither a man nor a woman specifically, and many feel as though their biological sex (male, female, etc.) and their socialized gender (man, woman, etc.) don’t match up. Some opt to change/reassign their sex through hormones and/or surgery and some change their outward appearance, or gender expression, through clothing, hairstyles, mannerisms, etc. Many people who identify as transgender feel as though they are confined in a binary system (male-female, man-woman) that does not match who they feel themselves to be. If we look at gender as a continuum and not an “either/or” concept, we have a better idea of understanding this issue.
7. **Transsexual:** Transsexual is used to describe those individuals who use hormone therapy and/or surgery to alter their sex.
8. **Intersex:** The word intersex refers to people who, on a genetic level, are not male or female. They are individuals whose sex chromosomes are not xx or xy, or who are born with ambiguous genitalia (hermaphrodites). Surgery performed in infancy or childhood, without informed consent, leaves some of these individuals feeling incomplete or altered.

For more information, please refer to the web site for the [Intersex Society of North America](#).

10. **Questioning:** People who are in the process of questioning their sexual orientation are often in need of support and understanding during this stage of their identity. They are seeking information and guidance in their self-discovery.
11. **Ally:** An ally is an individual who is supportive of the GLBTQ community. They believe in the dignity and respect of all people, and are willing to stand up in that role.
12. **Homosexual:** The word homosexual is a scientific term invented in the 1800's to refer to individuals who are sexually attracted to their own sex/gender. This term is not widely used in the GLBTIQA community as it is seen as too clinical.
13. **Heterosexual:** The term heterosexual was created around the same time to describe individuals who are sexually attracted to the opposite sex/gender. These words are still widely used, though they tend to perpetuate an "us versus them" mentality and a dichotomous sex/gender system.
14. **Straight:** The word straight is a slang word used to refer to the heterosexual members of our community.
15. **Heterosexism and Homophobia:** The term heterosexism refers to the assumption that all people are heterosexual and that heterosexuality is superior and more desirable than homosexuality. "Homophobia" is defined as "the irrational fear and hatred of homosexuals." Both of these are perpetuated by negative stereotypes and are dangerous to individuals and communities.
16. **Genderism:** The term genderism refers to the assumption that one's gender identity or gender expression will conform to traditionally held stereotypes associated with one's biological sex.
17. **Sexual Orientation:** One's sexual orientation refers to whom he or she is sexually or romantically attracted to. Some people believe that this is a choice (a preference) and others that it is innate (GLBT people are born this way).
18. **Gender Identity:** A person's gender identity is the way in which they define and act on their gender. Gender Expression is how they express their gender.
19. **Coming Out of the Closet:** The coming out process is the process through which GLBTQ people disclose their sexual orientation and gender identity to others. It is a lifelong process. Coming out can be difficult for some because societal and community reactions vary from complete acceptance and support to disapproval, rejection and violence. [The Human Rights Campaign](#) website has some very good information and resources on coming out.
20. **Queer:** The term queer has a history of being used as a derogatory name for members of the GLBTQ (and Ally) community and those whose sexual orientation is perceived as such. Many people use this word in a positive way to refer to the community; they have reclaimed the term as their own. Not everyone believes this and sensitivity should be used when using or hearing it as there are still many negative connotations with its use.
21. **Pansexual/Polysexual:** In recent years, the terms "pansexual" and "polysexual" have joined "bisexual" as terms that indicate an individual's attraction to more than one gender

From the University of Southern Maine's Center for Sexualities and Gender Diversity website; Definitions assembled by Sarah E. Holmes (GLBTQA Resources Coordinator) and Andrew J. Shepard, 2000 and 2002.

Appendix B: Specific Offender Population Best Practice Guidelines

II. For Providing Offender Treatment to Female Domestic Violence Offenders

The following Guidelines have been developed to address the unique aspects of treatment with female domestic violence offenders. These Guidelines supplement the DVOMB *Standards and Guidelines* and are found in the Appendix of the Standards.

A Specific Offender Population Subcommittee of the DVOMB was established to develop these Guidelines. The Subcommittee, comprised of state and local experts in the field of women's treatment and female offenders (including treatment providers, victim service providers and advocates, probation/corrections officers, and others involved in the criminal justice system) collaborated in the creation of these Guidelines. Clinical and professional expertise, as well as a review of available research and literature, served as the foundation for these Guidelines.

The treatment issues unique to female offenders require that providers working with this population have specific experience, knowledge, and assessment skills to effectively assess for and provide treatment to female offenders. While some female offenders may share race, class or other similarities, treatment providers are cautioned not to approach their work with or assumptions about female offenders from a single-lens perspective. Women of color, for example, may have vastly different life experiences than do white women, including the challenge of negotiating both gender-based violence and racism in their lives. It is imperative that treatment providers are prepared to assess and respond to the diversity of experiences and needs within female offender populations. Providers must seek appropriate training to work effectively with women who are racial or ethnic minorities, non-English speaking, of limited economic means, involved in prostitution or sex work, or who identify as lesbian, bisexual or transgender. The following outlines general training, assessment, treatment, and supervision issues related to effective work with female offenders. Providers are encouraged to use these guidelines as a baseline and seek additional training to increase competence in working with diverse groups of women.

The issues identified here should be integrated throughout intake evaluation and treatment, rather than approached as separate from the core of the treatment curriculum.

A. Competency, training and experience requirements for providers

1. Minimum competencies -obtained through core or basic trainings (10.03 Training Hours)
 - a. Sexism, gender stereotypes, including internalized sexism.
 - b. Women's experience of race, ethnicity and cultural issues; including internalized racism.
 - c. Assumptions of competency and adaptability of diverse cultures
 - d. Unique impact of violence on women
 - e. Origins of anger, modes of anger, levels of anger
 - f. Women's trauma issues (e.g., miscarriage, stillbirth, abortion, rape, sexual assault), including emotional/verbal abuse
 - g. Effects of domestic violence on victims

- h. Victim support issues, including safety plans
 - i. Drug/alcohol issues for women and victims
 - j. Dual arrests: predominant aggressor vs. co-combatant vs. victim
 - k. Probable cause arrest laws/policies/procedures
 - l. Parenting issues
2. Critical training areas - obtained through advanced trainings (See “Resources” and “Bibliography”)
 - a. Women and anger: stereotypes of women’s passivity or helplessness;
 - b. Race and class biases in women’s use of anger.
 - c. Self-defending victims: distinguishing “self-defense” from “retaliation” or “perpetration”
 - d. Working with “perpetrator”, “retaliator” and “victim” issues in the same group
 - e. A thorough understanding of Standard 4.06 and CRS 18-6-801(1)(a) for females who have been evaluated as inappropriate for domestic violence offender treatment.
 - f. Addressing past criminal issues (e.g., DOC)
 - g. Cultural competency training
 3. Field experience requirements (10.04)

B. Assessment of offenders [assessment should be conducted in the offender’s primary/dominant language]

1. Prior arrest and conviction history, including background check, criminal involvement related to partner (e.g., check fraud on behalf of partner, drug-related offenses with partner, prostitution/sex work). Prior criminal cases in which the offender was the identified victim (e.g., domestic violence, sex assault cases)
2. Female offender’s experience of violence in current relationship and barriers to accessing law enforcement and other services (e.g., class and economic issues, immigration status, institutional racism, language/cultural inaccessibility).
3. Potential retaliation by partner.
4. Physically abusive behaviors perpetrated in the past
5. Addiction history: drug/alcohol evaluations (SSI, ASI, ASAM and/or DSM); “meth rage”; criminal activities related to addiction (e.g., check fraud, sexwork)
6. Assessment of predominant aggressor tactics
7. Relationship assessment
 - a. Current status of relationship: Actual or threat of ongoing abuse by partner.
 - b. Mutuality assessment: Are both partners abusive? Only the defendant? Or only the “victim”?
 - c. Stalking, harassment, potential violence by current partner
 - d. Lethality assessment as appropriate
 - e. Prior violence: Was the defendant in other abusive relationships as either offender or victim?
8. Anger assessment: behaviors when angry; “triggers” for anger; emotional volatility
9. Rape, sexual abuse history, childhood history of victimization
10. Emotional, psychiatric and physical health issues acute for women (e.g., PTSD or other psychiatric issues related to adult/childhood victimization; reproductive difficulties, perimenopause, menopause; rate of suicidal ideation among female violence/trauma survivors)
11. Women’s use of lethal violence (See “Bibliography”)
12. Gender roles and attitudes toward women
13. Race/class stereotypes; internalized racism. In biracial couples, beliefs about self or partner’s racial identity.
14. Dependency issues, including socialization of women to be emotionally and financially dependent on male partner

15. Criminal thinking patterns unique to women
16. Current offense/arrest information: level of aggression (predominant aggressor vs. co-combatant vs. true victim)
17. Self-defending victims

C. Treatment Parameters and Dynamics (10.08)

1. Gender-specific groups are required.
2. Treatment should be conducted in the offender's primary/dominant language
3. Treatment awareness/sensitivity to race, class, cultural, language, and sexual orientation differences within the group
4. Trauma issues impacting women (e.g., abortion, rape, miscarriage, stillbirth)
5. Clinical use of group processing (e.g., relational interaction dynamics vs. didactical topic discussion)
6. Clinical immediacy (e.g., "Here and Now" vs "Theoretical or Idealized")
7. Sexual empowerment vs. compulsion
8. Trauma response and its effect on group: "trauma glasses"
9. Ego strength building without splitting or polarizing
10. Correctional facilities (e.g., Department of Corrections) considerations: individual vs. group treatment, "in-jail" groups, specialized case management
11. Dual-diagnosis groups
12. Ostracism within the group (e.g., boundaries vs. isolation)
13. Completion/Discharge
 - a. Unique aspects of accountability
 - b. Unique aspects of consistent use of time-outs
 - c. Less stereotypical roles in relationship
14. Unique safety parameters
Safety planning in response to ongoing abuse in the relationship
Possibility of retaliation by the partner

Curriculum of topics unique/acute to women (10.07)

Different "types" of anger (e.g., entitlement anger, 'fear-of-abandonment'-based anger, residual anger from past relationship, residual anger from prior adult or child victimization, rage issues, and appropriate anger as healthy response to injustice/violence)

Issues experienced by women (e.g., abortion, miscarriage, stillbirth, grief, rape or other sexual assaults, sexual harassment, emotional/verbal abuse). Perceived or actual social, racial, and/or class injustices experienced by some women. These issues may contribute to anger.

Integrating parenting and "motherhood" issues is critical for the treatment success of many female offenders. These concerns include child custody, children's safety, parenting skills, single parenting, reunification, step-children, childcare, attachment, custody, visitation, etc. Child Protection Services intervention.

Arrest and incarceration trauma experienced by some female offenders
Accountability for behavior, despite partners behavior (i.e. no blaming)

Supervision/consultation issues (10.05)

The supervisor/consultant should have expertise in working with both offenders and victims and have the adequate training in both areas

Victim advocacy (7.03b)

1. “Victim advocacy” to the system-defined victim may be described as “partner outreach” in recognition that the female defendant may in fact be the “predominant victim” in the relationship or that the system-defined victim may feel stigmatized by the term “victim”.
2. Awareness of and training in predominant aggressor issues, dual arrests, and co-combatant arrests. (Reference CRS18-6-803.6)
3. Training and expertise in providing advocacy/support in cases involving a victim-defendant inappropriately arrested.
4. Awareness of and training in working with diverse groups of women, including but not limited to race, class, sexual orientation, and gender identity differences.

Resources

Community-based domestic violence services/resources

For victims and offenders (heterosexual, same-sex, male, female, transgender)

Local therapists specializing in women’s issues and domestic violence

DVOMB/SOP Approved Treatment Providers

DVOMB/SOP Recommended Trainings

Bibliography

Research/literature re women and mental health, suicide, trauma, addiction, and criminality.

A Colorado Department of Criminal Justice study, *Community Corrections in Colorado: A Study of Program Outcomes and Recidivism, FY00-FY04* (released May 2006), indicated that “...women in female-only community corrections programs had much lower recidivism rates than did women in coed programs. Recidivism rates for women who successfully completed female-only programs were lower by approximately one-third, compared to women in coed programs”. http://dcj.state.co.us/ors/pdf/docs/Comm_Corr_05_06.pdf

Warden In Pink, by Tekla Miller (former warden describes differences she noted between male and female offenders).

Suggested reading:

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Selected Definitions

[Not all relevant terms will be defined here. Definitions of clinical, treatment, and training terms and concepts (e.g., “Post Traumatic Stress Disorder” or “internalized racism”) should be addressed in training and/or treatment curriculum materials.]

1. Predominant Aggressor: Refers to the individual who, in the incident or historically in the relationship, maintains power and control over their partner through the use or threatened use of violence. Also refers to CRS 18-6-803.6(2) which directs peace officers to assess the following when evaluating complaints of domestic violence from two or more parties: “(a) any prior complaints of domestic violence; (b) the relative severity of the injuries inflicted on each person; (c) the likelihood of future injury to each person; and (d) the possibility that one of the persons acted in self-defense.”

2. Victim-Defendant: System-defined “defendant” in the case who has historically been the victim in the relationship.

3. Partner Outreach: Advocacy or assistance provided to the system-defined “victim” in the case. In situations involving victim-defendant arrest, the system-defined “victim” may have a history of using violence or the threat of violence to intimidate or control the victim-defendant. Additionally, the system-defined victim may feel stigmatized by term “victim”.

Appendix C: Glossary of Terms

Accountability: The full assumption of responsibility, without distortion, minimization, or denial, while also claiming responsibility for the abusive behaviors, accepting the consequences of those behaviors, and actively working to repair the harm and preventing future abusive behavior.

Aftercare Plan: An offender's written plan for utilizing concepts learned in treatment. This plan shall include ways to address individual risk factors, criminogenic needs and continued pro-social support systems in order to maintain non-abusive long-term change.

Anger Management Treatment: Is often a psycho-education and therapy based program to address a person's struggles or inability to manage their disruptive angry behavior. Anger management treatment shall never be a substitute for domestic violence offender treatment.

Application Review Committee (ARC): The Application Review Committee (ARC) is delegated the authority by the Domestic Violence Offender Management Board (DVOMB) within the Division of Criminal Justice (DCJ) to perform the functions identified in C.R.S. This includes reviewing all applications seeking approval in order to determine whether an applicant has met the requirements for listing status, including those applications by Approved Providers seeking a different status.

Approved Provider: An individual who advertises or sets him/herself forth as having the capacity, competencies, and training to evaluate and/or treat domestic violence offenders in the State of Colorado, and has been approved by the Domestic Violence Offender Management Board and whose credentials have been verified by the Department of Regulatory Agencies pursuant to Section 16-11.8-103, C.R.S.

Approved Provider Working with Specific Offender Populations: An Approved Provider who has demonstrated his/her ability to meet the criteria as described in the *Standards and Guidelines* and the application process for specific offender populations, and has been approved as a DVOMB provider by the Application Review Committee.

Assessment: An ongoing collection of facts to draw conclusions regarding an offender's progression or regression in treatment, which may suggest the proper course of action.

Assessment Tool: A tool used in conjunction with a thorough clinical assessment to determine diagnosis, risk factors, lethality, or the treatment needs of the offender.

Board: As defined in Section 16-11.8-102, C.R.S. The Colorado Domestic Violence Offender Management Board (DVOMB) is a policy board made up of 19 multi-disciplinary experts in the field of domestic violence who are charged with the responsibility for developing *Standards and Guidelines* related to the consistent and comprehensive evaluation, treatment, and continued monitoring of domestic violence offenders (16-11.8-101 C.R.S.). The DVOMB is organizationally located in the Colorado Department of Public Safety (CDPS), in the Division of Criminal Justice, Office of Domestic Violence and Sex Offender Management.

Case Management: The coordination and implementation of the cluster of activities directed toward supervising, treating, and managing the behavior of domestic violence offenders.

Colorado Department of Public Safety (CDPS): Colorado Department of Public Safety is responsible for staffing the Board pursuant to Section 16-11.8-103, C.R.S.

Clock Hours: 60 minutes in an hour.

Co-facilitation: Experiential hours accumulated by a future applicant, which are completed in the physical presence of a Full Operating Level or a Domestic Violence Clinical Supervisor Level provider. Co-facilitation hours may only be accumulated while the future applicant is also being supervised by a Domestic Violence Clinical Supervisor during the period of time co-facilitation is taking place.

Competencies, Additional: Some offenders have additional risk factors that require demonstration of additional competencies. Additional competencies shall be required for offenders based on risk factors and individual treatment needs, as determined at the initial evaluation or during Treatment Plan Reviews. Examples of additional competencies are listed in *Standard 5.08VI (A-G)*.

Competencies, Core: Core Competencies represent the goals of treatment and are measured throughout treatment by the MTT. There are 18 core competencies listed in *Standard 5.08V (A-R)*. These competencies shall be demonstrated by offenders prior to discharge.

Containment: The process of restraining, halting, and preventing the offender from engaging in further violence against an intimate partner through the application of supervision, surveillance, consequences, restrictions, and treatment as imposed by the courts, supervising agents of the courts, and approved providers.

Couples Counseling: A prohibited intervention while a domestic violence offender is receiving domestic violence offender treatment.

Criminal Justice System: Includes activities and agencies, whether state or local, public or private, pertaining to the prevention, prosecution and defense of offenses, the disposition of offenders under the criminal law and the disposition or treatment of juveniles adjudicated to have committed an act which, if committed by an adult, would be a crime. This system includes police, public prosecutors, defense counsel, courts, correction systems, mental health agencies, crime victims and all public and private agencies providing services in connection with those elements, whether voluntarily, contractually or by order of a court.

Criminogenic Needs: A term used to reference offender dynamic factors such as substance abuse (alcohol and other drugs), antisocial attitudes, personality traits, associates, employment, marital and family relationships, and other dynamic variables statistically shown to be correlated with criminal conduct and amenability to change (Andrews & Bonta, 1994). As dynamic risk factors, criminogenic needs may contribute towards criminal behavior (e.g., domestic violence), and if effectively addressed, should decrease level of risk (Andrews, 1989, Andrews & Bonta, 1994; Bonta, 2002).

Denial, Severe: This level of denial consists of offenders who deny committing the current offense and refuse to acknowledge responsibility for even remotely similar behaviors. Offenders may also appear excessively hostile or defensive. This type of denial is the most resistant to change and may require other interventions or may not be amenable for treatment. See Standard 5.06 and 5.08 for more details.

DVOMB Approved Provider List: The DVOMB Approved Provider List is a list that identifies the providers who are eligible to receive referrals to provide evaluation, treatment, and assessment services to domestic violence offenders in Colorado.

Domestic Violence: Pursuant to Section 18-6-800.3(1), C.R.S., “domestic violence” means an act or threatened act of violence upon a person with whom the actor is or has been involved in an intimate relationship. “Domestic violence” also includes any other crime against a person, or against property, including an animal, or any municipal ordinance violation against a person, or against property, including an animal, when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship. The term also includes, but is not limited to the following definitions:

- a) Physical abuse: Strangulation, punching, hitting, kicking, shoving/pushing, blocking exits, restraining, or biting.
- b) Spiritual abuse: Using religion as an excuse to abuse/control, forbidding someone from attending church, or putting down someone’s faith.
- c) Sexual abuse: Sexual putdowns, treating someone like a sexual object, forcing/coercing/withholding sex, having or threats of having an affair, or refusing/forcing use of birth control.
- d) Psychological abuse: Threats of suicide or homicide, threatening gestures/actions, denial of abuse, gaslighting, or stalking.
- e) Using culture: Someone not being allowed to participate in mainstream culture, or using culture as excuse for abuse/control.
- f) Verbal abuse: Yelling, swearing, sarcasm, putdowns, name calling, degrading, or objectifying comments.
- g) Social abuse: Isolation from someone’s friends or family, monitoring calls and/or emails, or use of privilege as excuse to control.
- h) Using children: Abuse of children, threaten to harm or take children, using visitation to harass or belittle in front of children.
- i) Pets and property: Threats or acts of harm to pets, punching holes in the wall, or breaking property (phone, car, etc).
- j) Financial abuse: Controlling finances, not paying child support, making the victim to account for all spending, forcing or having the victim to pay for offender treatment, prohibiting employment, or forcing someone to work against their will.
- k) Intellectual abuse: Making someone question their intellect or self-worth, calling someone stupid, ignorant, or dumb, or attacking someone’s ideas or opinions.

Domestic Violence Clinical Supervisor: An Approved Provider who meets the qualifications identified in *Standard 9.0*, and has been approved as such by the ARC as a Domestic Violence Clinical Supervisor.

Domestic Violence Risk Assessment: A valid and reliable assessment tool which identifies

risk factors for domestic violence recidivism. The most recent version of the instrument shall be utilized.

Department of Regulatory Agencies (DORA): The Department of Regulatory Agencies is responsible for supervision and control of the mental health professional boards and unlicensed psychotherapists pursuant to Section 12-43-101, et. seq., C.R.S.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. Providers who utilize this manual shall use the most current version.

Emergency Action: In the event of a public safety issue, the ARC Chair Person in conjunction with the ODVSOM Program Manager may remove a provider from the Approved Provider List and take any necessary action to inform the proper law enforcement and regulatory authorities.

Executive Session: The members of the DVOMB, or the ARC, upon affirmative vote of two-thirds of the quorum present may hold an executive session to discuss legal issues with the DVOMB attorney or to review personnel and confidential information as noted in the Colorado Open Meetings Law (Section 24-6-402(4), 24-6-402(3)(a)(III), 24-6-402(3)(a)(IV), 24-6-402(3)(a)(XII), 13-90-107 (1)(g), 13-90-107 (1)(k), C.R.S.).

Evaluator: An Approved Provider who conducts either pre- or post-sentence offender evaluations according to the Standards contained in this document, and according to professional standards. Only licensed mental health professionals who are Approved Providers shall conduct pre-sentence evaluations.

Face-to-Face Clinical Contact Hours: The actual time an applicant or Approved Provider spends with an offender in person, in the same room, at the same time conducting evaluations, sessions, or other therapeutic interventions. E-therapy is prohibited under these Standards.

Indigent Offender: Individual who is declared indigent by the courts based on the federal poverty guidelines.

Interstate Compact/Out-Of-State Domestic Violence Offenders: When a domestic violence offender seeks domestic violence offender treatment in Colorado, on a case from another state, the Approved Provider will comply with Section 17-27.1.101 et. Seq., and must receive approval from the Interstate Compact Office for each offender, prior to providing any clinical services to the offender. Failure to comply may result in legal and monetary penalties pursuant to Section 17-27.1-101(9)(a) and 17-27.1-101(7), C.R.S. Offender must be fingerprinted where attending treatment, not where person lives.

Intimate Partner: Pursuant to 18-6-800.3(2), an intimate relationship means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time.

Lethality Assessment: Lethality assessment is the identification of risk factors that may be linked to intimate partner homicide (Jurik & Winn, 1990). Although there are overlapping concerns, risk assessment, lethality assessment, and safety planning are not the same. Victims may or may not be aware of their level of risk. This information can be used to identify potential risk in an offender and for safety planning for victims.

LGBTQIA+: Abbreviation for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual/Agender/Aromantic, etc. Umbrella term utilized to refer to victims and offenders in this community as a whole.

Multi-Disciplinary Treatment Team (MTT): A group of professionals comprised at a minimum of the DVOMB approved domestic violence offender treatment provider, judicial supervising officer and Treatment Victim Advocate, designed to collaborate and coordinate offender treatment.

Office of Behavioral Health (OBH): The Office of Behavioral Health, formerly Division of Behavioral Health (DBH), and Alcohol and Drug Abuse Division (ADAD), is responsible for licensing substance abuse programs, pursuant to Part 2 of Article 2 of Title 25, C.R.S.

Offender: Pursuant to Section 16-11.8-102, C.R.S, any person who on or after January 1, 2001, has been convicted of, pled guilty to, or received a deferred judgment and sentence for any domestic violence offense which includes any crime where the underlying factual basis as defined in Section 18-6-800.3 (1), C.R.S.

Offender Accountability: The offender claiming responsibility for his/her abusive behaviors, accepting the consequences of those behaviors, and actively working to repair the harm and preventing future abusive behavior.

Offender Contract: The signed treatment agreement between the Approved Provider and the offender that specifies the responsibilities and expectations of the offender, Approved Provider, and MTT. All items identified on section 5.05, II, A, B, C and D shall be included in the signed offender contract.

Offender Evaluation: The systematic collection and analysis of psychological, behavioral, and social information; the process by which information is gathered, analyzed, and documented for an offender to undergo a pre- or post-sentence evaluation prior to engaging in domestic violence offender treatment.

Offense: Any crime in which the underlying factual basis is an act of domestic violence.

Open Meetings: All meetings of the DVOMB or its committees shall be subject to the provisions of the Colorado Open Meeting Law (Section 24-6-401 et seq., C.R.S.).

Personal Change Plan: An offender's personal change plan includes a plan for preventing abusive behaviors, identifying triggers, identifying cycles of abusive thoughts and behaviors, as well as a plan for preventing or interrupting the triggers and cycles. This plan is to be designed and implemented during treatment and utilized after discharge as well.

Protection Order: A criminal or civil court order prohibiting or limiting offender access to victims and sometimes children or animals.

Protective Factors: Conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk in families and communities.

Responsible Criminal Justice Agency: The criminal justice agency that has jurisdiction and/or responsibility for supervision of the offender.

Responsivity: Effective service delivery of treatment and supervision requires individualization that matches the offender's culture, learning style, and abilities, among other factors. Responsivity factors are those factors that may influence an individual's responsiveness to efforts that assist in changing an offender's attitudes, thoughts, and behaviors.

Risk: Services provided to offenders should be proportionate to the offenders' relative level of static and dynamic risk (i.e., low, moderate, or high risk) based upon accurate and valid research-supported risk assessment instruments (Bonta and Wormith, 2013). The risk principle indicates that criminal behavior is predictable and that treatment services need to be matched to an offender's level of risk.

Risk Assessment: A tool utilized to assess offender risk, treatment needs, aid in diagnosis, and which informs treatment planning.

Second Clinical Contact: Offenders who are higher risk to victims and the community require more intensive treatment and supervision designed to address an offender's criminogenic needs. Second clinical contacts require adjunct treatment interventions that are based on the offender treatment plan and shall comply with the Position Paper Regarding Second Clinical Contacts (November, 2013).

Sliding Fee Scale: As defined in Section 18-6-802.5, C.R.S., a sliding fee scale is a policy and procedure that is written and available to all clients and is based on criteria developed by the Approved Provider. The fee scale has two or more levels of fees and is based on the offenders' ability to pay. The fee scale is available to each offender. Approved Providers must not withhold this information from clients.

Specific Offender Populations: Defined as a group of individuals who share one or more common characteristics such as race, religion, ethnicity, language, gender, age, culture, sexual orientation and/or gender identity that would allow for the group to be considered homogenous.

Specific Offender Populations - Assessment Criteria: A section of the Appendix B containing criteria based on research and literature for working with specific offender populations. This section may be periodically modified.

Stalking: Pursuant to 18-3-602(1), C.R.S., a person commits stalking if directly, or indirectly through another person, the person knowingly:

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- a) Makes a credible threat to another person and, in connection with the threat, repeatedly follows, approaches, contacts, or places under surveillance that person, a member of that person's immediate family, or someone with whom that person has or has had a continuing relationship; or
- b) Makes a credible threat to another person and, in connection with the threat, repeatedly makes any form of communication with that person, a member of that person's immediate family, or someone with whom that person has or has had a continuing relationship, regardless of whether a conversation ensues; or
- c) Repeatedly follows, approaches, contacts, places under surveillance, or makes any form of communication with another person, a member of that person's immediate family, or someone with whom that person has or has had a continuing relationship in a manner that would cause a reasonable person to suffer serious emotional distress and does cause that person, a member of that person's immediate family, or someone with whom that person has or has had a continuing relationship to suffer serious emotional distress.

Standards Compliance Review: A process undertaken by the ARC to conduct a review of an Approved Provider in order to determine the level of compliance with the *Standards and Guidelines*, areas for improvement or sustainment, and to identify any best practices.

Supervising Agents: The probation, parole, community corrections case manager to whom the offender's case is assigned.

Therapeutic Alliance: The formation of a positive relationship between the client and the therapist which consists of the following core elements: (1) an agreement on the treatment goals, (2) collaboration on the tasks that will be used to achieve the goals (specific interventions), and (3) an overall bond that facilitates an environment of progress and collaboration. However, developing a therapeutic alliance is often a dynamic and challenging process with forensic populations due to the involuntary nature of mandated treatment (Skeem et al., 2007).

Supervision Contract: Contract between Domestic Violence Clinical Supervisor and supervisee (applicant or approved provider), delineating agreements of supervision, agreements of supervisor and agreements of supervisee.

Training: Specific education instruction that supports the philosophy and principles as described in the *Standards and Guidelines*.

Training, Demonstrated Equivalent Experience and Training: The ability to document the equivalent experience and training for a specific requirement.

Treatment: As defined in Section 16-11.8.102, C.R.S, treatment means therapy, monitoring, and supervision of any domestic violence offender which conforms to the *Standards and Guidelines* created by the DVOMB. Consistent with current-research and professional practices, domestic violence offender treatment is the comprehensive set of planned therapeutic experiences and interventions designed to uniquely change the power and control, abusive thoughts, and behaviors. Such treatment specifically addresses the occurrence and dynamics of domestic violence and utilizes differential

strategies to promote offender change. Much more importance is given to the meeting of all treatment goals than the passage of a specific amount of time, since offenders make progress in treatment at different rates. Treatment is more successful when it is delivered consistently and with fidelity to the individual needs of the offender.

Treatment Amenability: Amenability to domestic violence treatment refers to the offender's capacity to effectively participate, function, and understand treatment concepts. Significant cognitive (e.g., thinking) impairments can preclude an individual's ability to sufficiently pay attention during treatment sessions, learn new information, and/or self-reflect. Similarly, some cases of acute mental illness may interfere with participation due to the presence of impaired reality testing (e.g., delusions or hallucinations).

Treatment Plan: The written Treatment Plan shall include goals that specifically address all clinical issues identified in the intake evaluation. The treatment goals shall be based on offender criminogenic needs, offender competencies, and identified risk factors. A Personal Change Plan and an Aftercare Plan shall be components of the Treatment Plan. Treatment plan must include Personal Change Plan and Aftercare plan. Section 5.05, I.

Treatment Plan Review: The purpose of the Treatment Plan Review is to re-assess offender degree of progress and risk, and to make any necessary modifications to the Treatment Plan and goals. All offenders shall have at least the minimum number of required Treatment Plan Reviews at identified intervals based on level of treatment and individual Treatment Plan(s). Section 5.07.

Treatment Program: A program that provides treatment as defined in Section 16-11.8.102 (4), C.R.S. by one or more approved providers.

Treatment Report: At a minimum of once a month, approved providers shall submit a written report to the supervising criminal justice agency that includes results from most recent offender Treatment Plan Review; progress regarding competencies; recommendations related to discharge planning; level of treatment; evidence of new risk factors; and offender's degree of compliance with fees, attendance, and level of participation. Section 8.06.

Treatment Victim Advocate: The person who works in conjunction with the Approved Provider and the domestic violence community to provide advocacy to the victim, as outlined section 7.0.

Vicarious Trauma: A state of tension or emotional distress by professionals working in a service related field due to a preoccupation with the thoughts, behaviors, and reenactments of the abuse by offenders against victims. Sometimes referred to as compassion fatigue, vicarious trauma can impact a person's professional or personal life, such as relationships with friends and family, as well as the person's overall health, both emotional and physical.

Victim: A person who is or has been the target of domestic violence as defined in the Glossary.

Victim Advocate: See Treatment Victim Advocate.

Victim, Secondary: Secondary victims are children, relatives, or other individuals who are impacted emotionally, psychologically, or physically by virtue of their relationship or involvement with the trauma suffered by the primary victim.

Appendix D - Administrative Policies

This Appendix is designed for listed Domestic Violence Offender Management Board (DVOMB) Approved Providers (hereafter referred to as Providers) pursuant to Section 16-11.8-103, C.R.S., as well as those who have filed a Trainee Application for listing status with the Domestic Violence Offender Management Board (DVOMB). The DVOMB does not have professional licensing authority, but rather statutory authority pursuant to section 16-11.8-101, et. seq. The provisions of this Appendix constitute the processes of the DVOMB related to applications, listing, denial of placement, complaints, appeals and other administrative actions.

The Director of the Division of Criminal Justice (DCJ) may suspend or modify any of these procedures in the interest of justice to avoid irreparable harm to crime victims or to the citizens of Colorado. If the situation warrants, the DVOMB may exercise the option of seeking guidance from the Office of the Attorney General for possible legal action.

I. LISTING STATUS AS A PROVIDER

- A. This Appendix applies to individuals who are listed in the following categories:
 - 1. Trainee Status
 - 2. Practicing Status
 - 3. Not Currently Practicing Status
 - 4. Inactive Status
- B. There are four types of active practice levels:
 - 1. Provisional Level
 - 2. Entry Level
 - 3. Full Operating Level
 - 4. Domestic Violence Clinical Supervisor
- C. Providers not on the DVOMB Approved Provider List (hereafter Provider List) including any provider who is denied placement or removed from the Provider List, shall not provide any treatment, evaluation, or assessment services pursuant to statute in Colorado to domestic violence offenders. Per Section 16-11.8-104, C.R.S., referral sources “shall not employ or contract with and shall not allow a domestic violence offender to employ or contract with any individual or entity to provide domestic violence offender treatment evaluation or treatment services pursuant to this article unless the individual or entity appears on the approved list developed pursuant to section 16-11.8-103 (4).”
- D. Requirements for Not Currently Practicing Status
 - 1. Not Currently Practicing - If a Provider wishes to retain their listing status but is not providing any evaluation, treatment, coverage, peer consultation or clinical supervision services for domestic violence offenders, the Provider may request to be placed on Not Currently Practicing Status. During this time, a Provider will retain their status on

the Provider List, but shall not provide any domestic violence offender services including treatment, evaluations, coverage, and peer consultation or clinical supervision. The Not Currently Practicing status may be requested by the Provider at any time.

2. The Provider may not remain under not currently practicing status longer than two renewal cycles (4 years). Following completion and approval of the second renewal application, the Provider must either relinquish listing status completely or move to a practicing status.
 3. Before a Provider who is under Not Currently Practicing Status may resume providing evaluation, treatment, coverage, peer consultation or clinical supervision, the Provider shall notify the DVOMB in writing of the intention to resume providing such services (including the name of a supervisor for those who are Entry or Provisional Level providers, or a required peer consultant for those who were Full Operating Level Providers) and receive written verification from the DVOMB of the submission.
 4. If necessary, the ARC may request the Provider to submit documentation of their compliance with the *Standards* prior to or within six months of resuming a practicing status. The listed provider shall meet the minimum qualifications (e.g. training, clinical experience, competency, staying active in the field, etc.) to maintain prior listing status and practice level (Provisional Level, Entry Level, or Full Operating Level).
- E. Providers shall submit data consistent with the DVOMB’s data collection plan and participate in, and cooperate with, DVOMB research projects related to evaluation or implementation of the Standards or domestic violence offender management in Colorado in accordance with sections C.R.S. 16-11.8-103(4)(a)(IV).
- F. Confidentiality of DVOMB Files - Information contained in the DVOMB files, including application materials for applicants, Providers, and those who have filed an Intent to Apply are considered confidential and are not available to the public. This includes background investigations, criminal history checks⁴⁹, school transcripts, letters of recommendation, trade secrets, confidential commercial data including applicant forms created for business use, curriculum developed for the business and clinical evaluations. Any information that, if disclosed, would interfere with the deliberation process of the Application Review Committee (ARC) of the DVOMB is also subject to this policy. The Colorado Open Records Act applies to other materials (Section 24-72-201, C.R.S.).
- G. Applicants or Providers may receive up to one year, or as deemed by the Application Review Committee, to come into compliance with any Standards. If they are unable to fully comply with the Standards at the time of application, it is incumbent upon the treatment provider or evaluator to

⁴⁹ According to the Colorado Bureau of Investigations (CBI), the Division of Criminal Justice (DCJ) may provide a copy of the Applicant’s/Provider’s CBI report to the Applicant/Provider by postal mail or in person at no charge. However, DCJ is not authorized to release a copy of an Applicant’s/Provider’s Federal Bureau of Investigations (FBI) report. The Applicant/Provider must request a copy of this record directly from the FBI.

submit in writing a plan to come into compliance with the Standards within a specified time period.

H. Maintenance of the DVOMB Approved Provider List

1. DVOMB staff shall maintain the Provider List on the DCJ website. Paper copies will be provided and distributed upon request.
2. The DVOMB will update and publish any changes to a Provider's status on the Provider List in accordance with Section 16-11.8-103(4)(c), C.R.S.
3. Individuals on the provider list shall notify the DVOMB in writing within 10 calendar days of any arrest, conviction, nolo contendere plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, felony, and/or the commencement of any civil dispute involving an underlying factual basis of domestic violence. The Colorado Bureau of Investigation (CBI) will notify the DVOMB if a Provider is held or arrested and then fingerprinted. The DVOMB will consider such information, including the Provider's proper notification of the DVOMB, in deciding whether to take administrative action regarding a Provider's approval status.

II. APPLICATIONS FOR LISTING STATUS

The purpose of the application process is to allow for applicants to demonstrate their individual competencies, qualifications, and abilities toward working with domestic violence offenders. Applicants must demonstrate compliance with the Standards through any application. There is an application associated with each listing status that must be submitted to the ARC prior to approval being granted.

A. Types of Applications

1. Trainee Application - This application is for individuals who want to begin the process of becoming a DVOMB Approved Provider. Applicants regardless of their credentials must complete the application and receive approval from the Application Review Committee (ARC) prior to beginning any co-facilitated services to domestic violence offenders. Upon approval, applicants will be conditionally designated as Trainees and do not appear on the Provider List.
2. Practice Level Application for Status - This application is for Trainees seeking placement on the Provider List at the Provisional Level, Entry Level, or Full Operating Level or currently Approved Providers seeking to move-up in practice level. At a minimum, applicants must have previously completed and received approval by the Application Review Committee (ARC) with the Trainee application. Applicants must demonstrate that they meet the qualifications of, and compliance with the Standards for Treatment with Court Ordered Domestic Violence Offenders published by the Domestic Violence Offender Management Board (hereafter referred to as the Standards).

3. Additional Applications - These applications are for individuals who have received approval or are in the process of applying for placement on the Provider List and who are seeking placement as a Domestic Violence Clinical Supervisor (DVCS), a Pre-Sentence Evaluator, or who are seeking approval to work with a Specific Offender Population (SOP).
4. Renewal Application for Continued Placement - Applicants who are currently on the Provider List and are seeking to remain as on the Provider List.

B. General Requirements for Applications

1. Provision of Services - New applicants intending to work towards becoming an Approved Provider shall submit a Trainee Application and be approved by the ARC, prior to accumulating co-facilitation hours. Once approved as a Trainee, the applicant is not presumed to be approved nor identified on the DVOMB Approved Provider List for the status the applicant is seeking.
2. Documentation - All information requested in the application shall be submitted. Failure to comply with the application requirements will result in the denial of the application and/or continued placement for a specific listing status on the Provider List.
3. Time Limits - With exception to renewal applications, all pending applications automatically expire after eight months from the initial date of the ARC initial review. If the ARC is experiencing a delay in processing an application, an extension may be granted to the applicant on a case-by-case basis.
4. Requests for Extensions - Applicants may request an extension prior to the expiration of an application or before the due date of an application. Requests for an extension by an applicant shall demonstrate in writing the need for an extension. For renewal applications, the required fee must be submitted with a request for extension.
5. Fees - The DVOMB assesses fees to cover the costs of processing applications. Refer to *"The Application Fee Schedule"* for the fee schedule for each listing status. Application fees are non-refundable and may not be transferred to another individual, but may be used as payment for other DVOMB functions on a case-by-case basis.

C. Continued Placement Requirements

1. Renewal Application - All Providers who are currently on the Provider List, including Not Currently Practicing Status, shall submit a renewal application every two years in order to maintain placement on the Provider List.

2. Grace Period for Renewal - Providers who do not submit an application for renewal of their status by the expiration date will have a 30-day grace period in order to submit their application materials. Failure to submit application materials within 30 days after the date of expiration for approved provider status will require providers to have to begin the application process by submitting a Trainee Application.
3. Eligibility for Future Renewal Once Provider Approval Has Expired

III. TYPES OF ACTIONS RELATED TO APPROVAL RELATED TO LISTING STATUS

- A. Approval - The ARC has determined that the applicant or Provider has met the minimum requirements to provide services to domestic violence offenders in Colorado and will be eligible to receive referrals by appearing on the Provider List.
- B. Modified Approval - The ARC has determined that the applicant or Provider has met a portion of the minimum requirements to provide services to domestic violence offenders. In such cases, the ARC can grant modified approval for offender services with restrictions and set conditions for that approval.
- C. Voluntary Removal - The Provider has requested to be removed from the Provider List without duress of a pending complaint or Standards Compliance Review (SCR). Upon removal, services shall not be provided to domestic violence offenders in Colorado by the requesting individual.
- D. Reduction in Status - Based on the determination of the ARC, a Provider's status is reduced (e.g., Domestic Violence Clinical Supervisor reduced to a Full Operating Provider) for a period of time and subject to the requirements of that approval level upon the effective date of the reduction.
- E. Denial - The ARC has determined that the applicant has NOT met the minimum requirements to provide services to court ordered domestic violence offenders in Colorado. The applicant is denied placement on the Provider List and shall not provide services in Colorado to domestic violence offenders.
- F. Involuntary Removal - Based on the determination of the ARC, an Approved Provider is denied placement on the Approved Provider List and shall not provide any services in Colorado to domestic violence offenders upon the effective date of removal. This includes Approved Providers who are removed as a result of not being able to demonstrate compliance with the Standards following a denial, a Standards Compliance Review (see Section V), or a founded complaint (see Section VI).
 1. Process for Replacement After Involuntary Removal - Providers involuntarily removed from the Provider List are required to submit a Trainee Application prior to submitting a Practice Level Application for Status. When submitting a Trainee Application, Providers involuntarily removed must address the concerns and/or compliance issues to the satisfaction of the ARC. Providers involuntarily removed shall apply at the

Entry Level first prior to becoming eligible to apply for Full Operating Level. This provision does not apply to Providers who were involuntarily removed from the Provider List solely as a result of the expiration of a DORA license, registration, or certification, so long as the provider applies for replacement when current with DVOMB renewal.

IV. BASIS FOR ARC ADMINISTRATIVE ACTION REGARDING DENIAL, REDUCTION, OR REMOVAL FROM THE PROVIDER LIST

The DVOMB can deny, reduce, or remove placement on the Provider List for any specific listing status to any applicant or Provider under these Standards. Reasons for denial, reduction, or removal include, but are not limited to:

- A. The ARC determines that the applicant or Provider does not demonstrate the qualifications required by these Standards;
- B. The ARC determines that the applicant or Provider is not in compliance with the Standards of practice outlined in these Standards;
- C. The applicant or Provider fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures;
- D. The ARC determines that the applicant or Provider exhibits factors (e.g., boundaries, impairments, etc.) which renders the individual unable to provide services to offenders;
- E. The ARC determines that the results of the background investigation, the references provided or any other aspect of the application process are unsatisfactory.
- F. The ARC determines that the overall work product submitted does not adequately demonstrate skills or competencies for the status being sought for by an applicant.

Those applicants or Providers who are denied, reduced, or removed from a specific listing status on the list will be provided with a copy of the DVOMB Administrative Policies. Administrative actions taken by the ARC regarding the listing status of a DVOMB Approved Provider does not constitute an action taken against the registration, licensure, or certification by the Department of Regulatory Agencies.

V. STANDARDS COMPLIANCE REVIEWS

The purpose of Standard Compliance Reviews (SCR) is to ensure that Providers are adhering to all applicable *Standards for Treatment with Court Ordered Domestic Violence Offenders* and to identify innovative and exceptional practices in areas related to domestic violence offender evaluation, assessment, and treatment. The ARC may conduct SCRs at any time. Once a Provider has successfully completed an SCR, he or she will be exempt from random selection for six years.

A. Types of Standard Compliance Reviews:

1. *For Cause* - The ARC may vote to initiate a For Cause SCR when notified that a Provider is not following a requirement of the Standards. The Provider will be given the opportunity to demonstrate compliance with the Standards through documentation submitted to the ARC during the SCR process.
 2. *Random* - The ARC conducts periodic SCRs on a randomized basis to determine if a Provider is following the requirements of the Standards. The DVOMB Approved Provider will be given the opportunity to demonstrate compliance with the Standards through documentation submitted to the ARC during the SCR process.
- B. Provider Notification - Providers will receive a notification letter for being selected for a SCR. The notification letter will also include an instructional packet requesting documentation for the ARC. All materials must be submitted by the Provider by the deadline identified in the notification letter.
- C. SCR Review - The ARC will review the completed SCR packet and any other relevant information concerning the DVOMB Approved Provider in order to identify any Standard violations, innovations, or best practices.
- D. SCR Outcomes - The ARC will notify the DVOMB Approved Provider in writing of the SCR outcome within 21 days of the ARC review. The SCR will identify at least one or more of the following outcomes:
1. The Provider is approved for continued placement.
 2. An innovative practice is identified as a best practice.
 3. Standards violations were founded and the Provider is offered a Compliance Action Plan (CAP) in lieu of being reduced in status or removed from the Provider List for a specific listing status.
 4. Standards violations are found to be pervasive or egregious enough that the ARC determines remediation through a CAP is unwarranted and the Provider is, therefore, removed from the Provider List pursuant to Section IV of this policy. Concerns related to Standards violations may also result in the submission of a formal complaint to the Department of Regulatory Agencies (DORA), per Section XI of this policy.

VI. COMPLAINTS

In the provision of services to domestic violence offenders, actions by an individual that violate the Standards or any general practice requirements of their certification, license, or registration, can be reported as a formal complaint to the DVOMB. Formal complaints received by the DVOMB are reviewed by the ARC and shall be forwarded to the Department of Regulatory Agencies (DORA) for processing. Formal complaints can be made against a DVOMB Approved Provider or against

someone who has provided domestic violence offender services without DVOMB approval per Section 16-11.8-104, C.R.S.

- A. When a complaint is made against a Provider, the complaint shall be made in writing to the DVOMB using the most current forms and signed by the complainant. Upon receipt, DVOMB staff will notify the complainant in writing of the receipt of the complaint. All complaints will be subject to an initial administrative review by DVOMB staff to determine: (1) if the DVOMB has purview to review the complaint, (2) if the complaint process has sufficiently alleged a violation, and (3) if the information provided does not allow for the ARC to process and review the complaint. Insufficient or improper complaint filings may not be accepted for review and the DVOMB staff will provide written notice to the complainant. Anonymous complaints should be submitted directly to DORA.
 1. Lack of Purview: The alleged violation behavior does not fall under the statutory authority of the DVOMB. In order for purview to exist, the provider shall be:
 - i. Approved by the DVOMB per 16-11.8-103 of the C.R.S.;
 - ii. Providing services consistent with the *Standards* per 16-11.8-103 C.R.S.;
 - iii. Providing services to a person who meets the definition of a “Domestic Violence Offender” under 16-11.8-102 C.R.S.
 2. Sufficiently Alleged: The alleged violation behavior in question as described by the complainant, if true, would constitute a violation of a specific Standard.
 3. Not Sufficiently Alleged: The alleged violation behavior as identified by the complainant, even if true, would not constitute a violation of a specific Standard for the Provider serving a client under the purview of the DVOMB.
- B. All complaints will be forwarded for investigation and review to DORA pursuant to Section 16-11.8-103(4)(IV)(b), C.R.S. Concurrently, the DVOMB will review the complaint for potential action pursuant to Section 16-11.8-103(3)(D), C.R.S. DVOMB staff, in consultation with the ARC, will provide input to DORA regarding any alleged violations of the *Standards*. Any complaints sent directly to DORA regarding Providers will also be reviewed by the DVOMB staff, in consultation with the ARC. The appropriate DORA mental health board will determine the complaint either as founded or unfounded.
 1. Unfounded Complaints - If DORA determines the complaint as unfounded, the DVOMB will notify the complainant in writing. The outcome of an unfounded complaint will result in no formal action taken by the ARC and the Provider’s file will not reflect any documentation regarding the complaint.

2. **Founded Complaints** - If DORA determines the complaint as founded, the DVOMB will notify the complainant in writing. Following the

disposition issued by DORA, the ARC may take administrative action in addition to any conditions or stipulations administered by DORA which may include possible options for remediation such as a Compliance Action Plan (CAP) and/or changes to a Provider's listing status. Any founded complaint in one listing status shall result in a review of the Provider's other approvals which may subsequently impact the listing status of other approval categories (e.g., a founded complaint against a Provider approved to work with female offenders may impact the Provider's approval with LGBTQIA+ offenders).

- C. If the ARC determines that remediation is not possible and votes to remove the Provider from the Provider List, referral sources will be notified following the procedures identified in Section IV of this policy.

VII. REQUEST FOR RECONSIDERATION AND APPEAL PROCESS

Any applicant or DVOMB Approved Provider under these Standards who disagrees with a decision made by the ARC regarding denial, reduction, or removal from the Provider List related to a particular status or approval may exercise two administrative options in the following order:

1. Request for reconsideration by the ARC; and
2. Appeal any final decision made by the ARC to the DVOMB following a request for reconsideration.

Requests for reconsideration and appeals are limited to complaints, denial for placement on the Provider List for a specific listing status, the involuntary removal from the Approved Provider List, or for a reduction in approval status.

A. Request for Reconsideration of the ARC

1. Submitting A Request - Applicants or Providers must submit a request for reconsideration in writing to the DVOMB within 30 days from the date of receipt of the notification letter. A request for reconsideration shall include supporting documentation that meets one of the following criteria:
 - The documentation relied upon by the ARC was in error;
 - There is new documentation relevant to the decision of the ARC was not available at the time for consideration;
 - The ARC lacked sufficient grounds to support the decision made;
 - The ARC failed to follow the DVOMB Administrative Policies.

2. ARC Review - The ARC will perform a subsequent review of its initial decision to deny, reduce, or remove an applicant or Provider from a specific listing status. The ARC will first determine if the request for reconsideration satisfactorily addresses the criteria for review. If the ARC determines the request for reconsideration meets criteria, then the ARC will deliberate and consider the documentation submitted. Upon review the ARC can vote to:
 - a) Uphold the original decision to deny, reduce, or remove with or without modifications. This final decision by the ARC can be appealed to the DVOMB.
 - b) Modify the original decision to deny, reduce, or remove. This final decision by the ARC can be appealed to the DVOMB.
 - c) Reject the original decision to deny, reduce, or remove.
3. Decision Notification - ARC communication of decisions will be provided in writing within 21 days after the ARC decision is made.

B. Appeal to the DVOMB

1. Submitting a Request to Appeal the Decision of ARC - Applicants or DVOMB Approved Providers must submit a request to appeal in writing to the DVOMB within 30 days from the date of receipt of the notification letter to uphold or modify the ARC decision following the request for reconsideration. A request to appeal shall include supporting documentation and meet the following criteria:
 - The documentation relied upon by the ARC was in error;
 - There is new documentation relevant to the decision of the ARC was not available at the time for consideration;
 - The ARC lacked sufficient grounds to support the decision made;
 - The ARC failed to follow the DVOMB Standards or policy in making its decision.
2. Parties affected by the appeal may include an applicant, a Provider, or a complainant. All parties affected by an appeal will receive notification of the date, time and place of the appeal, along with the deadline for submission of additional materials. These additional materials must be limited to 10-15 pages and be received by the DVOMB 60 days prior to the hearing. Materials received after the deadline or not prepared according to these instructions will not be reviewed at the scheduled appeal hearing.
3. DVOMB Review - The DVOMB will only consider information specific to the finding outlined by the ARC in the notification letter.

- a) Copies of the appeal materials (subject to redactions or other protections to comply with statutorily contemplated confidentiality concerns) considered by ARC will be provided to the DVOMB and parties involved at least 30 days prior to the hearing and the parties and the DVOMB are expected to make every effort to maintain confidentiality of the materials.
 - b) Either party may request alternate electronic means to meet with the DVOMB in lieu of appearing in person. The request must be made in writing at the time of the request for the appeal.
 - c) Appeals will be scheduled in conjunction with regular DVOMB meetings. The appellant must confirm, in writing, their ability to attend the scheduled appeal; failure of the appellant to do so may result in the appeal being dismissed. The DVOMB staff and the DVOMB chairperson will jointly review requests for an extension or to reschedule an appeal. Parties will be notified verbally or in writing, as applicable, regarding the decision on the request for an extension or to reschedule. Requests will be reviewed based on reasonable causes.
 - d) Parties involved may bring one representative with them. Appeal hearings (in person or via electronic means) will be 80 minutes long: 20 minutes for a verbal presentation by the complainant (if available); 20 minutes for the identified provider; 20 minutes for presentation by the ARC; and 20 minutes for questions and discussion by the Board. Applicable time periods may be modified upon request, by either party or a DVOMB member, followed by a motion by a DVOMB member and a vote on the motion.
 - e) There must be a quorum of the DVOMB to hear an appeal. ARC members count towards establishing a quorum, but must abstain from voting on the appeal per DVOMB By-laws.
 - f) The DVOMB will consider appeals in open hearing and audio record the proceedings for the record unless certain material must be considered by the DVOMB in executive session pursuant to Section 24-6-402(3)(a)(III), C.R.S. Any vote will occur in open session.
 - g) The DVOMB must vote on the original findings of the ARC. They must vote in one of the following three ways:
 - i. Uphold the decision of the ARC.
 - ii. Reject the decision of the ARC.
 - iii. Uphold the decision of the ARC and modify the proposed administrative action taken by the ARC.
4. Decision Notification - The results of the appeal will be documented via letter sent to all parties within 30 days after the date of the appeal hearing.

- a) Founded complaint records will be retained for 20 years per the Division of Criminal Justice Records Retention Policy.
- b) The appeal process is the sole remedy for an applicant or Provider who is denied, reduced, or removed from a specific listing status on the Provider List, or resolution of a complaint(s). The decision of the DVOMB is final.

VIII. VARIANCES

The purpose of the Standards Variance Process is to allow for a DVOMB Approved Provider or applicant to seek approval for a temporary suspension of a specific Standard. The reasons for suspending a requirement of the Standards vary, but modifications to requirements of the Standards are limited to rare circumstances that are reviewed on a case-by-case basis. Variance requests can be related to the treatment for an offender or to request a modification to the approval process.

- A. Submitting A Variance Request - A Provider who is unable to comply with the requirements of the Standards may submit a variance proposal to the ARC for review. The proposal should be identified as a Standard Variance Request and must include the following components:
 - 1. Identification of each Standard that is subject to the variance;
 - 2. An overview of the unusual circumstances and documentation why compliance with the Standards is not possible;
 - 3. A plan developed for the proposed variance of outlining the following:
 - a) Victim safety including re-offense and lethality considerations
 - b) Enhanced offender containment strategies
 - c) Ongoing assessment of offender risk and progress
 - d) Timeframe
 - e) Written verification of MTT consensus
- B. Preliminary Review - DVOMB Staff and at least one ARC member will perform an initial review of the request. If the request is acceptable, they will authorize preliminary approval of the plan until the ARC can conduct a formal review at the next meeting. If the request is not acceptable, the ARC member and the Staff will work with the Provider to modify and address any questions or concerns. Variances that are not granted preliminary approval will be scheduled for formal review by the ARC at the next meeting. The Provider will be notified in writing of the decision to approve or deny preliminary approval of the variance.
- C. ARC Review - The ARC will review the Standards Variance Request. If preliminary

approval was granted, the ARC may uphold that decision or modify the variance. The ARC will ratify the Standards Variance Request and create a plan for conducting periodic reviews and any necessary documentation required for those

reviews. The ARC has the authority to set forth specific program conditions during the time frame of the variance request.

IX. TECHNICAL ASSISTANCE

Questions pertaining to the application and interpretation of the Standards can be directed toward the DVOMB staff who are available to provide clarification and support as needed and applicable on a case by case basis. DVOMB Approved Providers and other individuals who use the Standards are encouraged to contact DVOMB staff with questions when technical issues arise.

Appendix E: Resource and Guide to Terms and Concepts of the Pre-Sentence or Post-Sentence Evaluation Standards

Please Note: This document is designed to be a resource guide for working with, assessing, and evaluating offenders. It is intended that approved providers will utilize their expertise along with this guide in working with offenders. Approved providers will make their own decisions regarding the degree of information that needs to be gathered for each offender and how to collect that information.

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I. Accountability

A. Definition

Accountability refers to “taking full responsibility for the effects of one’s actions.” In domestic violence intervention there are many aspects of accountability to consider and there are many ways to assess or measure it at various points of treatment. For example, accountability includes individual and unilateral responsibility (i.e., taking full unilateral responsibility for the effects of one’s own words or actions regardless of the influence of anyone else’s words or actions). Accountability can be diminished by unhealthy and self-limiting shame as differentiated from appropriate guilt. Low or limited levels of offender accountability can be correlated to high or extensive risks of offender reoffense. Low levels of empathy for the victim can also be correlated to high incidence of recidivism by the offender (Bancroft, 2002).

B. Assessment

Accountability can be assessed by considering the following:

1. Does the offender take responsibility for his/her abusive actions in the police report of the incident? In the victim report? In the other witness report(s)?
2. Does the offender take responsibility for his/her own actions regardless of the actions of the victim or witness(es)?
3. Does the offender take responsibility for any other reports of abuse in the relationship? In other relationships?
4. Is the offender willing to talk in treatment about his/her acts of abuse? Patterns of abuse?
5. Is the offender willing to write about his/her abusiveness?
6. Is the offender willing to receive input/feedback/confrontations from the therapist about the abuse? From the group?
7. Can the offender identify personal deficiencies/challenges/struggles that have played a role in his/her abusiveness?
8. Can the offender identify and describe personal tools/strategies/ interventions to be used to prevent future abusiveness?
9. Is the offender willing to commit to ceasing the abuse?

C. Measurement

Accountability can be measured by the following:

1. Offender verbal statement of accountability
2. Offender written statement of accountability
3. Offender written “as-if” letter of accountability to the victim. This letter is intended to be a therapeutic exercise and shall not be shared with the victim.

Accountability should be assessed continually:

1. At intake
2. Prior to any change in level of treatment
3. Following any change in risk of reoffense
4. Prior to discharge from treatment

II. Motivation for Treatment

A. Definition

Motivation or “readiness” for treatment refers to the degree to which an offender engages in the process of change. It includes considerations of how receptive the offender is to learning new information and receiving feedback about his/her behavior. Utilizing concepts from the Stages of Change model (Prochaska et al., 1994), the process of change occurs through several “stages” involving different thought processes, emotional responses, and behaviors. Though originally applied to substance abuse treatment, the Stages of Change model has since been applied to domestic violence treatment (Levesque et al, 2000; Eckhardt et al, 2004).

In domestic violence offender treatment the motivation for change refers to an individual’s “contemplation” of problematic or abusive behaviors, his/her receptivity toward this self-reflection, and the acknowledgement of the benefits of changing behaviors. Thus, self-awareness will increase motivation to change. Conversely, the tendency to blame others for one’s actions will decrease motivation for change, as others are seen as the “real” problem.

B. Assessment and Measurement

The following are considerations for assessing an offender’s level of motivation:

1. What is the offender’s attitude toward treatment? Is he/she compliant? Resistant? Open? Defensive? Dismissing?
2. How receptive is he/she to learning new information and receiving feedback about his/her behavior?
3. How willing is he/she to acknowledging and examining the effects of his/her behavior on others?
4. What is his/her level of personal insight?
5. Does he/she tend to externalize or blame others for his/her behavior?
6. Are there factors, such as a significant lack of empathy, which might interfere with a treatment alliance or engagement in the treatment process?

Consider the following for assessing motivation for change:

1. The Transtheoretical Model (TTM) and the Stages of Change (DiClemente et al., 1992).
2. URICA-DV developed by Levesque utilizes the Stages of Change with domestic violence offenders (Levesque *et al.*, 2000).

C. Treatment Considerations

1. Motivational Interviewing Model (Rollnick & Miller, 1995) has demonstrated utility with resistant clients.
2. The Transtheoretical Model (TTM) and the Stages of Change (DiClemente *et al.*, 1992).

III. Amenability to Treatment

Please Note: This document is designed to be a resource guide for working with, assessing, and evaluating offenders. It is intended that approved providers will utilize their expertise along with

this guide in working with offenders. Approved providers will make their own decisions regarding the degree of information that needs to be gathered for each offender and how to collect that information.

A. Definition

Amenability to domestic violence treatment refers to the offender's capacity to effectively participate, function, and understand treatment concepts. Significant cognitive (e.g., thinking) impairments can preclude an individual's ability to sufficiently pay attention during treatment sessions, learn new information, and/or self-reflect. Similarly, some cases of acute mental illness may interfere with participation due to the presence of impaired reality testing (e.g., delusions or hallucinations).

While some impairments may be the transient effects of medications or some other treatable physiological condition or disease process including mental illness, other conditions may be more longstanding or identified as permanent deficits. Examples of permanent deficits may include mental retardation, dementia, severe learning disabilities, or acquired brain dysfunction. The role of the approved provider is to assess whether the individual has the current capacity to effectively participate in, and benefit from treatment considering these deficits.

Additionally, the approved provider should identify what limitations exist and distinguish those that require accommodation and those that would indicate a lack of amenability. If the approved provider can accommodate, or refer to an approved provider who can accommodate limitations, the offender is expected to participate in treatment.

B. Assessment

1. Amenability to treatment can be assessed as part of the mental health assessment, though a more in-depth and specific evaluation may be warranted in some cases.
2. Various cognitive abilities should be assessed and accommodated (where appropriate) relative to the ability of the offender to effectively participate in treatment, including:
 - a. Attention
 - b. Memory (i.e., the ability to learn new information and/or to recall previously learned information)
 - c. Language comprehension
 - d. Reading comprehension
 - e. Verbal reasoning and abstract thinking or the ability to understand similarities between events and to learn from past experience
 - f. Executive functioning (e.g., planning, organizing, sequencing)
3. Cognitive impairment that should be assessed and accommodated (where appropriate) relative to effective offender participation includes, but is not limited to:
 - a. Mental retardation (i.e., significantly sub-average intellectual functioning with concurrent deficits in present adaptive functioning)
 - b. Dementia (i.e., a progressive decline in cognitive functioning)
 - c. Acquired brain dysfunction (e.g., traumatic brain injury)
 - d. Effects of medications and/or other physical conditions and treatments

4. Acute untreated or poorly managed mental health disorders may also interfere with an offender's capacity to participate in domestic violence treatment, particularly in a group setting. Approved providers need to assess whether these disorders can be accommodated in treatment. Some examples include, but are not limited to:
 - a. Schizophrenia with prominent symptoms of hallucinations, delusions, or disorganization
 - b. Bipolar disorder with acute mania
 - c. Major depressive disorders with the significant suicidal ideation
 - d. Social phobias that interfere with group treatment
 - e. Post traumatic stress disorder (PTSD) with severe symptoms of dissociation and/or intrusive re-experiencing
 - f. Significant psychopathy or antisocial personality features

C. Measurement

Cognitive screenings may be conducted as part of a mental health evaluation using well-known assessment instruments including but not limited to:

- The Mini Mental Status Examination (MMSE)
- The Galveston Orientation Assessment Test (GOAT)

The more detailed assessment of cognitive status often involves neuropsychological tests, IQ tests, and/or achievement tests, which evaluate specific clinical questions and abilities. Such evaluations are typically completed only by professionals with specialized training in the assessment of cognition; such as neuropsychologists, developmental or educational psychologists, and/or speech-language pathologists.

Mental disorders may be measured using the same instruments used during a mental health status assessment (e.g., Beck Depression Inventory, MMPI-2, MCMI-3), though psychopathy is commonly measured using the Hare Psychopathy Checklist (PCL-R) requiring specialized training.

D. Treatment Considerations

1. Accommodations for illiterate, hearing, or visually impaired offenders
2. Mental health and/or monitoring of medication management
3. In cases where the approved provider determines that an offender is not amenable to treatment, according to these guidelines, then the approved provider shall refer the offender back to the court with an alternative recommendation for treatment. The approved provider shall provide verifiable documentation to support the findings.
4. Though research varies on the effectiveness of treatment of psychopathy (Gacono, 2000; Skeem *et al.*, 2003; Vien & Beech, 2006), a number of studies have identified various nonspecific treatments that are considered inappropriate with psychopathic offenders, and may even contribute to an increase in violent recidivism following treatment (Hare *et al.*, 2000; Rice *et al.*, 1992). Generally, many psychopathic offenders may be considered inappropriate for domestic violence interventions as they tend to be disruptive during the treatment process in the absence of very highly structured treatment settings, and may be more likely to learn more effective ways to manipulate, deceive, and use others rather than change their violent-prone behaviors.
5. Regarding offenders with disabilities, Reference Standard 10.10 Offenders with Disabilities or Special Needs.

IV. Criminogenic Needs

A. Definition

Criminogenic needs is a term used to reference offender dynamic factors such as substance abuse (alcohol and other drugs), antisocial attitudes, personality traits, associates, employment, marital and family relationships, and other dynamic variables statistically shown to be correlated with criminal conduct and amenability to change (Andrews & Bonta, 1994). Criminogenic needs are aspects of an offender's situation that when changed are associated with changes in criminal behavior (Bonta, 2002). As dynamic risk factors, criminogenic needs may contribute towards criminal behavior (e.g., domestic violence), and if effectively addressed, should decrease level of risk (Andrews, 1989, Andrews & Bonta, 1994; Bonta, 2002).

Non-criminogenic needs are factors that may change but are not empirically related to a reduction in recidivism. Some examples are weight problems, self esteem issues, or witnessing domestic violence as a child.

B. Assessment

There are assessment instruments that capture information about these dynamic factors. An example is the Level of Service Inventory (LSI) that is often utilized by probation. The Spousal Assault Risk Assessment (SARA) is another example of a validated reliable instrument that is designed to be used as a clinical guide.

Various areas may be assessed to identify an offender's criminogenic needs, including:

1. Substance abuse
2. Antisocial attitudes (e.g., minimization, denial, or blaming)
3. Low levels of satisfaction in marital and family relationships
4. Antisocial peer associations
5. Identification and association with antisocial role models
6. Poor self-control and self-management
7. Poor problem solving skills
8. Poor social skills
9. Unstable living environments
10. Financial problems
11. Unemployment
12. Social isolation
13. Mental health

C. Measurement

A variety of measures have been created to assess criminogenic needs. Some are broader (e.g., risk-needs classification instruments such as the LSI-R), while others are more specific (e.g., measures of substance abuse, anger and hostility, antisocial attitudes). Examples of more specific measures include:

1. Addiction Severity Index
2. Simple Screening Inventory (SSI)
3. Aggression Questionnaire
4. Criminal Sentiments Scale (CSS)

D. Treatment Considerations

1. Substance abuse assessment and treatment
2. Development of pro-social attitudes
3. Development of a pro-social support system
4. Monitoring of employment status in collaboration with probation
5. Mental health assessment and treatment

V. Risk Principle and Needs Principle

A. Definition

The risk principle is an endorsement of the premise that criminal behavior is predictable and that treatment services need to be matched to an offender's level of risk. Thus, offenders who present a high risk are those who are targeted for the greatest number of interventions. When offenders are properly screened and matched to appropriate levels of treatment, recidivism is reduced by an average of 25 to 50 percent (Carey, 1997).

The needs principle pertains to the importance of targeting criminogenic needs and providing treatment to reduce recidivism. Criminogenic needs/dynamics risk factors are rehabilitative targets for treatment (Andrews & Bonta, 1994).

B. Treatment Considerations

Under treatment of high risk offenders and over treatment of low risk offenders is not effective. Therefore, offender risk needs to be matched to the level of treatment interventions. Additionally, when criminogenic needs are addressed in treatment, there is a likelihood of reduction in recidivism.

VI. Responsivity Principle and Factors

A. Definition

Responsivity factors are those factors that may influence an individual's responsiveness to efforts that assist in changing his/her attitudes, thoughts, and behaviors. These factors may or may not be offender risk factors or criminogenic needs. These factors play an important role in choosing the type and style of treatment that would be most effective in bringing about change for offenders (Andrews & Bonta, 1994).

B. Assessment (Bonta, 2000)

Thinking style: It is beneficial to gather information regarding offenders' thinking styles. Consider the following questions in your assessment:

1. Are they more verbally skilled and quick to comprehend complex ideas or are they more concrete and straightforward in their thought processes?
2. Will they be more responsive to treatment that requires abstract reasoning skills, or will they be more responsive to more straightforward and direct treatment modalities?

Anxiety regarding treatment: Evaluate whether offenders are anxious about treatment. Consider the following questions:

1. Are they more likely to better respond initially to individualize versus group treatment?
2. Is there some type of acute mental disorder such as delusions or a thought disorder, which may need to be managed in order for offenders to respond to treatment?

Personality dynamics: Consider whether there are personality dynamics that might influence the offender's response to treatment.

1. For example, many individuals with antisocial personality features tend to be more responsive to treatment that is highly structured as opposed to a more process-oriented style. Given a chronic level of low stimulation, such individuals may need a treatment style that is more active and stimulating as opposed to open discussion and quiet readings.
2. For offenders with various personality clusters, consider how these features can be utilized in treatment to assist the offender in engaging in treatment. For example, can reinforcement of changes be emphasized with the narcissistic offender to focus on his/her successes in treatment? Can the dependent offender learn to depend more on strategies learned in treatment and depend less on the victim?

Learning style: Consider the offender's learning style:

1. Is the offender an auditory, visual, or kinesthetic (experiential) learner?
2. Would the offender benefit more from a role play exercise or a reading assignment?

Personal and demographic: Consider whether the offender will respond better to treatment when other personal and demographic factors are considered and addressed. This might include geography, gender, ethnicity, language, sexual orientation, age, and/or other cultural factors.

VII. Lethality Assessment

This section is for informational purposes and is not synonymous with the term risk assessment. Lethality assessment is a subset of risk assessment.

A. Definition

Lethality assessment is the identification of risk factors that may be linked to intimate partner homicide (Jurik & Winn, 1990). Although there are overlapping concerns, risk assessment, lethality assessment, and safety planning are not the same. Victims may or may not be aware of their level of risk. This information can be used to identify potential risk in an offender and for safety planning for victims. Assessment of dangerousness or lethality risk of the offender is recommended by most experts (Ganley, 1989; Hart, 1988, Campbell, 2001).

Research studies suggest that there are differences in the reasons why men and women kill their intimate partners. There is considerable support for the gender role and self-protection models.

These models suggest that “women’s violence is often an outgrowth of the structural inequalities between men and women, and the resulting threat of men’s violence against women (Dobash & Dobash, 2000). When women kill, it is often in response to physical threat from their male victims (Browne, 1987). Such defensive reactions may be especially common among individuals who lack resources and access to legal responses (Black, 1983; also Williams & Flewelling, 1987:423). Compared to men, women more frequently kill in situations in which their victim initiated the physical aggression.”

“The most dramatic differences between homicides by men and women are found when examining the relationship history and situational dynamics leading up to the victim’s death. Women typically kill intimates-especially male partners-with whom they have experienced a long history of violent conflict (Chimbos, 1978; Totman, 1978; Silver & Kates, 1979; Daniel & Harris, 1982).

B. Assessment and Measurement

The Danger Assessment Instrument created specifically for female victims (Campbell et al., 2003) or Barbara Hart’s assessment of whether batterers will kill (1990), in addition to other information from multiple sources should be reviewed.

C. Treatment Considerations

1. Safety planning and education regarding risk factors and lethality factors with victims
2. Ongoing risk assessment from multiple sources
3. Monitoring for indicators that offender is escalating/de-escalating, decompensating, or becoming more stable

VIII. Mental Health Assessment

Please Note: This document is designed to be a resource guide for working with, assessing, and evaluating offenders. It is intended that Approved Providers will utilize their expertise along with this guide. Approved providers will make their own decisions regarding the degree of information that needs to be gathered for each offender and how to collect that information.

A. Definition

In the context of domestic violence offender treatment, mental health “assessment” refers to the process of assessing an offender’s current mental health status and identifying any factors that might directly impact level of risk for future violence or for re-offense. Some mental health conditions (e.g., social anxiety) may also indirectly increase level of risk by interfering with effective involvement in interventions.

Whereas a mental health assessment tends to cover a fairly broad domain, a mental health “evaluation” refers to a more formal procedure, normally requested by the court

or other referral source. This evaluation normally targets a specific clinical question or issue (e.g., capacity to participate in treatment). A mental health evaluation may incorporate various sources of information, including psychological testing, into a written report that details significant findings.

B. Assessment

Consideration should be given to whether or not there are contributing factors to the offender's mental health history or to his/her current status that may increase level of risk. Various aspects of an offender's mental health history or current status that should be assessed include, but are not limited to the following:

1. Psychotic disorders (e.g., schizophrenia, schizoaffective disorder, delusional disorder)
2. Mood disorders (e.g., bipolar disorder, major depression)
3. Anxiety disorders (e.g., post-traumatic stress disorder, panic disorder, obsessive compulsive disorder)
4. Personality disorders with anger, impulsivity, and poor behavioral controls (e.g., DSM -IV-R Cluster B personality disorders, or psychopathic/antisocial, borderline, narcissistic, or histrionic personality features).
Personality disorders have also been identified as a risk factor for spousal assault (Magdol, et al., 1997). Further, personality disorders have been associated with increased risk for criminal behavior, including violence and violent recidivism (Hare, 1991; Harris et al., 1993; Sonkin, 1987), and recidivistic spousal assault (Bodnarchuk, et al., 1995; Gondolf, 1998).
5. Past neurological trauma and/or current neurological symptoms

When mental health factors are identified in the assessment, a variety of issues should be considered:

1. What is the severity of the mental health condition?
2. Are symptoms current or historical?
3. Have symptoms ever resulted in psychiatric hospitalization?
4. Has an aspect of the mental health disorder (i.e., a delusion or hallucination) motivated or triggered past violence toward others?
5. Has an aspect of the mental disorder (i.e., a delusion or hallucination) motivated or triggered past suicide attempts or threats?
6. To what extent do symptoms disrupt or interfere with aspects of the offender's everyday life? (e.g., work, relationships)
7. Is there a concurrent substance abuse disorder that contributes toward an increase or worsening of symptoms?
8. Is the offender actively compliant with medication management?

The empirical literature suggests a positive correlation between psychosis and past violence (Swanson, Holzer, Ganju, & Jono, 1990; Monahan, 1992), and that treated psychosis is associated with a decreased risk for violent recidivism (Rice, Harris, & Cormier, 1992). Psychotic and/or manic symptoms are associated with an increased short-term risk for violence (Binder & McNeil, 1988; Link & Stueve, 1994), and that these symptoms may be associated specifically with spousal assault (Magdol, et al., 1997). Additionally, certain anxiety disorders may interfere with effective participation in treatment (Reference Section III.)

Most, if not all DSM-IV-R Axis I disorders can now be effectively treated with medication, psychotherapy, or both. Therefore, treatment becomes a significant mediating factor in the degree to which the disorder contributes toward ongoing risk of future violence or re-offense. Intervention is likely to be effective, though in some cases long-term treatment is the only effective intervention. Assessment questions related to mental health treatment may include the following:

1. Is the offender currently in treatment? (e.g., medications, psychotherapy)
2. How long has the offender been in treatment?
3. Is the offender compliant with treatment?
4. Has treatment been effective or helpful?
5. Has the offender been involved in any violent or abusive behavior while in treatment?
6. Are offender symptoms currently being managed?

C. Measurement

All approved providers should perform an initial screening or preliminary assessment. When further assessment is needed, the approved provider will perform this if he/she has the appropriate qualifications, or he/she will refer the offender to an approved provider who is qualified.

A variety of psychometric instruments or tests may be useful in assessing an offender's mental health status. Some advanced and lengthy instruments, such as the MMPI-2, are restricted in their use based upon clinical training qualifications or specific coursework involving a given instrument. Other brief instruments, such as the Beck Depression Inventory, have less specialized training requirements. Such instruments are typically used to supplement or augment collateral information, such as the clinical interview.

A few possible instruments that may be used to assess mental health status include, but are not limited to the following:

1. Minnesota Multiphasic Personality Inventory (MMPI-2)
2. Millon Clinical Multiaxial Inventory (MCMI-3)
3. Personality Assessment Inventory (PAI-2)
4. Mini Mental Status Exam (MMSE)
5. Beck Depression Inventory (BDI-2)
6. Beck Anxiety Inventory (BAI)

D. Other Considerations:

1. Personality Clusters

Research studies (Hamburger & Hastings, 1986) have indicated that domestic violence offenders tend to possess several types of personality clusters when tested utilizing the MCMI-3. The main clusters exhibited by domestic violence offenders include the following:

- a. Dependent, which constitutes about 35 percent of the offender population
- b. Narcissistic, which constitutes about 50 percent of the offender population
- c. Antisocial, which involves a multitude of various associated personality elevations and constitutes about 15 percent of the offender population

Research (Gondolf, 2001) has suggested that personality disorders are not correlated with risk of reoffense. However, clinical expertise sometimes reveals that offenders with certain personality elevations respond better to treatment when the clinical interventions are presented in a manner consistent with their specific personality.

2. A history of significant central nervous system trauma (e.g., traumatic brain injury, seizures or epilepsy, brain disease) has been identified as other factors that can contribute toward impulsive violence or aggressive behavior (Meloy, 2000). More specifically, frontal and/or temporal lobe dysfunction has been shown to be associated with various types of violent offending (Raine & Buchsbaum, 1996).

IX. Principles for Differentiating Treatment

A. Theories and Examples

There are a variety of constructs described below that can be used for differentiating offender treatment. The following principles may be applied to more broadly differentiated groups of offenders (e.g., offenders differentiated by language, male or female GLBT offenders, or male or female heterosexual offenders).

1. The first principle for differentiating treatment, repeatedly found to be valid in criminal justice interventions, is that higher and lower risk offenders should not be treated together (Lowencamp & Latessa, 2004).
 - a. “Lower risk offenders” can be more reliably identified with the use of researched risk assessment procedures (e.g., SARA) than by clinical judgment alone.
 - b. Efforts should be made to accentuate the natural strengths of lower risk offender groups. This includes avoiding overly intensive and costly intervention, avoiding exposure to more anti-social or violent associates, and/or utilizing overly remedial programming. It is also important to promote and to strengthen natural pro-social networks.
2. A second principle for differentiating treatment is that anti-social offenders need different programming from moderate and higher risk offenders.
 - a. Anti-social offenders should be treated in a separate group because they will contaminate other more pro-social members by interfering with the group process.
 - b. Anti-social offenders need a different treatment approach that focuses on their self-interest. Treatment should be more didactic and less process-oriented than other groups. Treatment should continue to be strongly oriented towards a containment model and strive to disrupt anti-social support networks. Treatment should not include victim empathy content that may be used against victims by these offenders.
3. A third principle for differentiating treatment for other moderate and higher risk offenders involves the differentiation of offender treatment based on criminogenic needs. Offenders with severe substance abuse problems, problematic personality traits, entrenched power and control issues, mental health disorders, etc., could be placed in different programming based on the resources and/or numbers of offenders in any given district. Examples include the following:

- a. A domestic violence/substance abuse program for offenders with prominent substance abuse involvement and resulting lifestyle instability.
 - b. An “enhanced domestic violence treatment program”, which is a group for moderate and higher risk offenders who are not highly anti-social.
 - c. A review of offender criminogenic needs will guide decision making regarding ancillary or adjunctive treatment recommendations. For example, an offender with bipolar disorder may need to be medically stabilized prior to participating in domestic violence treatment. An unemployed offender may need vocational assistance in addition to domestic violence treatment.
4. While offender responsivity issues should be considered in regard to making decisions about treatment for all offenders, when possible, responsivity can also guide differentiation in treatment programs (Reference Section VI). Examples include the following:
- a. A cognitive/behavioral approach utilized regardless of other responsivity factors.
 - b. Staff expertise, strengths, and/or approach matched with client needs. For example, anxious clients do poorly with highly confrontational therapists; less experienced therapists may be more easily manipulated by anti-social offenders.
 - c. Accommodation for intellectual levels/learning styles

X. Multi-disciplinary Treatment Team (MTT)

A. Definition, Purpose, Function,

The Multi-disciplinary Treatment Team (MTT) includes, at a minimum, three members: the supervising criminal justice agency (e.g., probation officer, the court), the approved provider, and the treatment victim advocate. The treatment victim advocate working with the approved provider is a critical member of the MTT. Whether or not the victim has been contacted, the victim advocate still has expertise and perspectives that are valuable to the MTT related to offender treatment planning and management. Other professionals relevant to a particular case may also be a part of the MTT.

The MTT’s purpose is to review and consult on offender cases as a team. Each member’s expertise and knowledge contributes something of value to the case coordination.

Where and when the MTT meets, and how the MTT functions are at the discretion of the MTT. This is purposefully designed to be flexible so that each community can determine how to best review cases.

Overview of the Multi-disciplinary Treatment Team (MTT)

1. **MTT Membership:** The MTT consists of approved provider, responsible criminal justice agency and treatment agency victim advocate at a minimum. Other professionals relevant to a particular case may also be a part of the MTT.
2. **MTT Purpose:** The MTT is designed to collaborate and coordinate offender treatment. Therefore the work of the MTT needs to include staffing cases, sharing information, and making informed decisions related to risk assessment, treatment, behavioral

monitoring, and management of offenders. The MTT by design may prevent offender triangulation and promote containment.

3. **MTT Consensus:** Consensus is defined as the agreement of the majority of the team members. The MTT shall have consensus as its goal in managing offenders. The MTT shall attempt to reach consensus for the following phases of treatment, at a minimum: initial placement in treatment, when treatment planning indicates a change in level of offender treatment and discharge. The supervising agent for the court will have the ability to overrule the decision of the team.
4. **Potential conflict within the MTT:** MTT members have the goal of settling conflicts and differences of opinion among themselves, which assists in presenting a unified response. The MTT may also request a meeting with a probation supervisor to review recommendations. In cases where consensus cannot be reached, the other team members may choose to justify in writing, utilizing offender competencies and risk markers, the reason for their recommendations for treatment.

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***Appendix G: Domestic Violence Risk and Needs Assessment
Instrument (DVRNA)***

- I. Annotated DVRNA
- II DVRNA Scoring Guide
- III. DVRNA Scoring Sheet

ANNOTATED DVRNA

(Domestic Violence Risk and Needs Assessment)

Prepared by Domestic Violence Unit
Division of Criminal Justice
Colorado Department of Public Safety
May 5, 2010

Introduction

The Domestic Violence Risk and Needs Assessment Instrument (DVRNA) is designed to identify risk factors that should be considered when working with domestic violence offenders in treatment. The DVRNA utilizes a structured decision-making process that improves the accuracy of decision-making based on risk assessment. This instrument presents a framework within which to assess the risk of future violence for domestic violence offenders in treatment. The DVRNA takes numerous risk factors that have been identified through empirical research as increasing the risk of violence or escalating its seriousness and consolidates these factors into a single measure, thus providing a method of determining the likelihood (probability) of ongoing or repeat violence.

The DVRNA was developed in conjunction with the revised *Standards and Guidelines for Treatment With Domestic Violence Offenders* Section 5.0 to address the different levels of treatment and how to classify an offender. Specifically, there is a need to be able to classify offenders according to risk because the research on offenders in general demonstrates that when risk corresponds to intensity of treatment, there is a greater possibility to reduce recidivism.

This instrument is comprised of 14 different empirically based domains of risk. Empirical evidence is used as a basis for the concept of differentiated treatment as well as to support each of the risk factors in the DVRNA. The basis of empirical evidence and previously validated instruments gives the DVRNA face validity. One of the tenets of the DVRNA is to guide initial treatment planning including the design of offender competencies that must be demonstrated by the offender and justification for changes to treatment plan, such as required additional treatment or reducing intensity of treatment.

The DVRNA has face validity. There is considerable consensus that risk assessment approaches must be rooted in the literature. The research has demonstrated that the most effective clinical assessment occurs with a validated risk assessment instrument in conjunction with clinical judgment. The DVOMB hopes to obtain funding in the future to perform a validation study on this risk assessment instrument.

Domestic violence risk assessment documents from other authors and “best practices” were evaluated. The primary risk assessment instruments utilized to create the DVRNA include the Spousal Assault Risk Assessment Guide, 2nd ed. (SARA), the Ontario Domestic Assault Risk Assessment, rev. ed. (ODARA), Level of Supervision Inventory, rev. (LSI VII), Domestic Violence Screening Instrument (DVSII), and the Danger Assessment Scale (Jacquelyn C. Campbell).

The most tested clinical assessment for assessing the risk of domestic violence is the SARA. The 20 factors included are characterized by criminal history, psychosocial adjustment, spousal assault history, and the index offense. Some items are related to the empirical research literature of the predictors of domestic violence or recidivism, whereas others were selected on the basis of clinical experience. The ODARA is a 13-item actuarial risk assessment constructed specifically for wife assault. The items were derived from information available to, and usually recorded by police officers responding to domestic violence calls involving male perpetrators and female partners. The Level of Supervision Inventory (LSI) developed by Andrews and Bonta is a 54-item risk/need classification instrument. This instrument is composed of ten subscales that contain both “static” (e.g. criminal history) and “dynamic” (e.g. alcohol/drug problems, family/marital) risk factors.

The DVSI, developed by the Colorado Department of Probation Services consists of 12 social and behavioral factors found to be statistically related to recidivism by domestic violence perpetrators while on probation. These questions are designed to elicit information that is pertinent to determining an offenders’ supervision level, including: (1) criminal history; (2) past domestic violence, alcohol, or substance abuse treatment; (3) past domestic violence restraining /protection orders, including violations; (3) previous non-compliance with community supervision, and (4) various other static and dynamic factors.

The Danger Assessment Scale developed by Jacquelyn Campbell for nurses, advocates, and counselors assesses the likelihood for spousal homicide. The first part of the tool assesses severity and frequency of battering by presenting the woman with a calendar of the past year. The second part includes yes-no questions that weigh lethality factors.

Risk factors were measured along two main dimensions. Criminogenic factors included substance abuse, psychopathy, pro offending attitudes and beliefs while the non-criminogenic dimension measured self-esteem, anger control, impulsiveness, anxiety, unemployment, social support and environmental factors. It was recognized that these dimensions did not act in isolation of each other, and any factor alone would not predict abusiveness.

The DVRNA cannot predict the behavior of any given individual. The single best predictor of future violent behavior continues to be past violence and we cannot, in any absolute sense, predict lethality or serious injury. The best we can do is to evaluate comparative risk and attempt to safeguard against identified dangers.

Guidelines for Use of the DVRNA

The following documentation is designed to be a resource for utilizing the DVRNA. Further explanations and definitions of the risk factors are provided here. These definitions are derived from the research that identified the risk factor. For several risk factors, there are numerous studies or articles identified. On occasion, the relevant portion of the study has been summarized for the purposes of this document.

The DVRNA includes 14 domains of risk that are identified as Domains A through N. When scoring the DVRNA, one should count a maximum of one point for each domain regardless of the number of items checked under each domain. Although there are sub-risk factors delineated under each domain, the maximum score for the entire instrument cannot exceed 14.

Domain A. Prior Domestic Violence Related Incidents (This domain applies only to adult criminal history):

1. Prior domestic violence conviction (ODARA, 2005) Critical Risk Factor that indicates initial treatment placement in Level C.
2. Violation of an order of protection (B-SAFER, 2005; Kropp & Hart, 2008; DVSI, 1998)
3. Past or present civil domestic violence related protection orders against offender.
4. Prior arrests for domestic violence (Ventura & Davis, 2004)
5. Prior domestic violence incidents not reported to criminal justice system (Cattaneo & Goodman, 2003).

The findings of the DVSI indicate that incidents involving multiple victims are highly associated with DVSI-R risk scores and recidivistic violence. Of the 12 items listed in the DVSI screening instrument, several items address domestic violence related incidents. These include prior arrests for assault, harassment, or menacing; and history of, and/or violations of domestic violence restraining order(s). The *Validation Study of the Domestic Violence Screening Instrument* (2008) reported that offenders arrested for violating a Temporary Restraining Order or Protective Order received the highest average DVSI score (11.56). Also, offenders arrested for “violating a temporary restraining order or protective order” accounted for the largest percentage of “high risk classifications” (64.9%).

The Ontario Domestic Assault Risk Assessment (ODARA) notes that a prior domestic incident whereby the offender assaulted his current or previous cohabiting partner and which is recorded in a police report or criminal record.

Domain B. Drug or Alcohol Abuse (Any of the following are Significant Risk Factors that indicate initial treatment placement in Level B at a minimum):

1. Substance abuse/dependence [as defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*] within the past 12 months (B-SAFER, 2005; Cattaneo & Goodman, 2003; Kropp & Hart, 2008; ODARA, 2005; Weisz, et al., 2000); or “drunkenness”/intoxication (Gondolf, 2002)
2. History of substance abuse treatment within the past 12 months (Andrews & Bonta, 2005; Kropp & Hart, 2008; Saunders & Hamill, 2003; Klein, 2008) or two or more prior drug or alcohol treatment episodes during lifetime (DVSI, 1998)
3. Offender uses illicit drugs or illegal use of drugs (Campbell, 1995)

The involvement of alcohol or drugs is a significant predictor of subsequent arrest. This finding highlights the recognized interrelationship between alcohol/drug use and battering and the need for offenders to receive treatment for both problems (Hirschel et al., 2007)

Information was obtained from a multi-site evaluation to identify risk markers and batterer types that might help predict re-assault and repeat re-assault. The research team preformed a number of analyses in an attempt to identify risk markers. One finding indicated the strong risk marker for drunkenness and women’s perception of safety and future assault. The substantial risk marker of drunkenness did not necessarily imply a causal link - that heavy alcohol use causes violence. Drunkenness may be a manifestation of an underlying need for power. Drunkenness coupled with previous violence may, furthermore, identify unruly men with chaotic and violent lifestyles or subcultures (Gondolf, 2002).

Recent substance abuse/dependence is identified as an item on the SARA Checklist, which identifies factors to consider when assessing the risk for future violence in domestic violence offenders. Recent substance misuse is associated with risk for violent recidivism among wife assaulters (Kropp & Hart, 2008). Additionally, the DVSI identifies “prior drug or alcohol treatment or counseling” as a factor in managing and predicting risk of future harm or lethality in domestic violence cases and the ODARA identifies substance abuse as a risk factor.

According to the results of a data collection project, performed by the Domestic Violence Offender Management Board staff utilizing over 5,000 responses, twenty-seven percent of offenders in domestic violence treatment also received drug and alcohol counseling, the most frequently identified adjunctive service (Henry, 2006).

Jacquelyn Campbell’s research on femicide clearly indicates that perpetrator drug abuse significantly increased the risk of intimate partner femicide, but only before the effects of previous threats and abuse were added. Drug abuse, therefore, was associated with patterns of intimate partner abuse that increase femicide risks (Campbell et al, 2003).

In a study of 11,870 white men logistic models were used to estimate the odds of mild and severe husband-to-wife physical aggression. Being younger, having lower income, and having an alcohol problem significantly increased odds of either mild or severe physical aggression. Also, a drug problem uniquely increased the risk of severe physical aggression. Marital discord and depression further increased odds of aggression (Pan et al, 1994).

The prevalence of the overlap between substance abuse and relationship violence is generally high, and that this is most evident in high-risk samples (i.e. those that are positive on either relationship

violence or substance abuse.). Research over the past 20 years has confirmed that substance use and abuse is a significant correlate of domestic physical violence. Longitudinal investigations carried out in this area have yielded strong support for the causal role of husbands' heavy use of alcohol in the perpetration of male-to-female partner violence during the early years of marriage (Wekerle & Wall, 2002).

Domain C. Mental Health Issue (Any of the following are Significant Risk Factors that indicate initial treatment placement in Level B at a minimum):

1. Existing Axis I or II diagnosis (excluding Vcodes)
2. Personality disorder with anger, impulsivity, or behavioral instability (Kropp & Hart, 2008; B-SAFER, 2005)
3. Severe psychopathology (Gondolf, 2007; Huss & Langhinrichsen-Rohling, 2006))
4. Recent psychotic and/or manic symptoms (Kropp & Hart, 2008)
5. Psychological/psychiatric condition currently unmanaged
6. Noncompliance with prescribed medications and mental health treatment
7. Exhibiting symptoms that indicate the need for a mental health evaluation

Barbara Hart created a list of several indicators demonstrated by batterers who have killed or tried to kill their intimate partners. One such item listed is “depression.” When a batterer has been acutely depressed and perceives little hope for overcoming the depression, he/she may be a candidate for homicide and suicide. Research demonstrates that many men who are hospitalized for depression have homicidal fantasies directed at family members (Hart, 1990).

Personality Disorder with Anger, Impulsivity, or Behavioral Instability is identified as an item in the SARA Checklist. Personality disorders characterized by anger, impulsivity, and behavioral instability (e.g., psychopathic/antisocial, borderline, narcissistic, or histrionic personality disorder) are associated with increased risk for criminal behavior, including violence and violent recidivism. In addition, “Recent Psychotic and/or Manic Symptom” is identified as an item on the SARA Checklist.

Edward Gondolf and colleagues investigated the psychological characteristics of the repeat re-assaulters in their multi-site evaluation by further interpreting the men’s MCMI-III profiles. Approximately half of the repeat re-assaulters did show some evidence of psychopathic tendencies in the broadest sense of psychopathy. A relatively small portion (11%, about 1 in 10) of repeat re-assaulters exhibited primary psychopathic disorder - the classic coldhearted psychopathy of greatest concern. Nearly two thirds (60%) had sub-clinical or low levels of personality dysfunction (Gondolf, 2002).

Domain D. Suicidal/Homicidal: Serious homicidal or suicidal ideation/intent within the past year (Kropp & Hart, 2008)

1. Serious homicidal or suicidal ideation/intent within the past year (Kropp & Hart, 2008), Critical Risk Factor that indicates initial treatment in Level C
2. Ideation within the past 12 months (Kropp & Hart, 2008; B-SAFER, 2005).
3. Credible threats of death within the past 12 months (Kropp & Hart, 2008; Campbell, 2008)
4. Victim reports offender has made threats of harm/killing her (female victims in heterosexual relationships¹ (Campbell, 2008)

Homicidal or suicidal ideation within the past 12 months is a valid indicator that the perpetrator may continue to be violent towards his partner. Men who murder their intimate partners often report experiencing suicidal ideation or intent prior to committing their offense; in fact, it is not unusual for these men to attempt or even complete suicide after the murder. Moreover, empirical research suggests that there is a link between dangerousness to self and dangerousness to others (Kropp & Hart, 2008; Campbell, 2008).

“The more the batterer has developed a fantasy about who, how, when, and/or where to kill, the more dangerous he may be. The batterer who has previously acted out part of a homicide or suicide fantasy may be invested in killing as a viable ‘solution’ to his problems. As in suicide assessment, the more detailed the plan and the more available the method, the greater the risk” (Hart, 1995).

¹ Jacquelyn Campbell’s work in this document refers to her work on femicide and only female victims in heterosexual relationships.

Domain E. Use and/or Threatened Use of Weapons in Current or Past Offense or Access to Firearms:

1. Gun in the home in violation of a civil or criminal court order (Vigdor & Mercy, 2006). Critical Risk Factor that indicates initial treatment in Level C.
2. Use and/or threatened use of weapons in current or past offense (Kropp & Hart, 2008; Azrael & Hemenway, 2000, Hart, 1990)
3. Access to firearms (Langley, 2008; Paulozzi et al. 2001; Mitchell & Carbon, 2002; Campbell, 2003; Saltzman, et al., 1992; Klein, 2008). “Access” to firearms is defined as personal ownership of a firearm or living in a household with a firearm.

A 2000 study by Harvard School of Public Health researchers analyzed gun use at home and concluded: “hostile gun displays against family members may be more common than gun used in self-defense, and that hostile gun displays are often acts of domestic violence against women.” This study presents results from a national random digit dial telephone survey of 1,906 U.S adults conducted in the spring of 1996. Respondents were asked about hostile gun displays and use of guns and other weapons in self-defense at home in the past five years. The objective of the survey was to assess the relative frequency and characteristics of weapons-related events at home (Azrael & Hemenway, 2000).

A study by the Centers for Disease Control and Prevention regarding homicide among intimate partners found that female intimate partners were more likely to be murdered with a firearm than by all other means combined. Women who were previously threatened or assaulted with a firearm or other weapons were 20 times more likely to be murdered by their abuser than other abused women. The study concluded that the figures demonstrate the importance of reducing access to firearms in households affected by intimate partner violence (Paulozzi, et al., 2001).

Risk factors identified among a majority of experts include access to/ownership of guns, use of weapons in prior abusive incidents, and threats with weapon(s) (Campbell, 1995).

Abusers’ previous threats with a weapon and threats to kill were associated with substantially higher risks for femicide. Campbell’s research indicates that abusers who possess guns tend to inflict the most severe abuse. Additionally, gun owning abusers’ have a much greater likelihood of using a gun in the worst incident of abuse, in some cases, the actual femicide. (Campbell et al., June 2003).

In an analysis of the danger assessment risk factors, 15 of the 17 items distinguished intimate partner homicide victims from abused women. The factor with the strongest risk (highest odds ration) was use (or threatened use) of a weapon. Those women were 20 times more likely to be killed as other abused women (Campbell et al., 2004).

The SARA utilizes the indicator, “use of weapons and/or credible threats of death in the most recent incident” as an indicator of abuse. “Credible” means the threats were perceived as credible by the victim (e.g., “I’ll get you”) (Kropp & Hart, 2000).

Considerable research suggests that the likelihood of death in an expressive assault is related to the availability of a weapon. (Saltzman, et al., 1992) have reported that overall firearm-associated family and intimate assaults were 12 times more likely to be fatal than non-firearm associated family and intimate assaults.

Domain F. Criminal History - Nondomestic Violence (Both Reported and Unreported to the Criminal Justice System) (This domain applies only to adult criminal history):

1. Offender was on community supervision at the time of the offense (DVSI, 1998). Critical Risk Factor that indicates initial treatment in Level C
2. Offender has a prior arrest for assault, harassment, or menacing (DVSI, 1998; Buzawa, et al., 2000; Ventura & Davis, 2004) If there have been two or more arrests, it is a Significant Risk factor that indicates initial treatment in Level B at a minimum.
3. Prior nondomestic violence convictions (DVSI, 1998; Klein, 2008; ODARA, 2005; Ventura & Davis, 2004)
4. Past violation(s) of conditional release or community supervision (bail, probation -Kropp & Hart, 2008; B-SAFER, 2005; ODARA, 2005).
5. Past assault of family members, strangers, or acquaintances (Kropp & Hart, 2008; Weisz, et al., 2000; B-SAFER, 2005)
6. Animal cruelty/abuse (Humane Society, 2007; Volant et al., 2008; Ascione, 1998; Faver & Strand, 2003; Ascione, 2007; Ascione, et al., 2007).

Criminal history is an important part of risk assessment. It is a long-established predictor of future behavior. The versatility, stability, and frequency of the offender's criminal behavior patterns are key risk factors for recidivism (Andrews & Bonta, 2005).

Offenders with a history of violence are at increased risk of spousal violence, even if the past violence was not directed towards intimate partners or family members. Research has shown that generally violent men engage in more frequent and more severe spousal violence than do other wife assaulters (Kropp & Hart, 2008).

Of the 12 items listed in the DVSI screening instrument, questions were designed to elicit information regarding an offender's criminal history. These include prior non-domestic violence convictions and history of any form of community supervision at time of offense. Offenders who have violated the terms of conditional release or community supervision are more likely to recidivate than are other offenders. In a validation study of the DVSI based on all DVSI assessment completed between August 2003 and July 2007 by the State of Hawaii, the most commonly reported risk factor (43.5%) was prior non-domestic violence convictions (Hisashima, 2008).

A study using data from the Spousal Assault Replication Program (SARP), sponsored by the National Institute of Justice examined (1) the extent to which criminal domestic violence offenders specialize in violence and (2) whether the severity of an offender's attacks against the same victim increase, decrease or stay about the same over time. The specialization analysis revealed that criminal domestic violence is part of a larger cluster of serious problem behaviors in the lives of the people who commit it. Few SARP domestic violence offenders had been specializing exclusively in violence. Many offenders were identified with violence in their official criminal histories, but the overwhelming majority of these individuals also committed nonviolence offenses. The domestic violence offender who is arrested only for violent criminal activity appears to be the exception rather than norm (Piquero et al., 2005).

Most studies agree that the majority of domestic violence offenders that come to the attention of the criminal justice system have a prior criminal history for a variety of non-violent and violent offenses, against males as well as females, domestic and non-domestic. A study of intimate partner arrests in Connecticut, Idaho, and Virginia of more than a thousand cases, for example, found that

almost seventy percent (69.2%) had a prior record, 41.8% for a violent crime (Hirschel, et al., 2007).

A study of the Cook County (Chicago) misdemeanor domestic violence court found that about three-quarters of defendants had a prior domestic abuse charge, and over 80% had a prior simple assault charge. Fifty seven percent of the men charged with misdemeanor domestic violence had prior records for drug offenses, 52.3% for theft, 30.8 % for weapons violations, 68.2% for public offenses, and 61.2% for property crimes. These men averaged 13 prior arrests (Hartley & Frohmann, 2003).

Not only did most of the abusers brought to the Toledo Ohio Municipal Court for domestic violence have a prior arrest history, but the average number of prior arrests was fourteen. A majority of batterers (69%) had been arrested for at least one violent misdemeanor, including and in addition to domestic violence. And 89 percent had been arrested for one or more non-violent misdemeanor (Ventura & Davis, 2004).

Similarly, 84.4 percent of domestic violence offenders in a study performed in Massachusetts were previously arrested for a wide variety of criminal behaviors; 54 percent having 6 or more criminal charges (Buzawa et al., 2000).

Animal Cruelty

Batterers tend to threaten, abuse, or kill animals to demonstrate and confirm power and control over the family, to isolate the victim and children, to teach submission, to perpetuate the context of terror, and to punish the victim for leaving. A 1997 survey of 50 of the largest shelters for battered women in the United States found that 85% of the agencies surveyed reported that women discuss pet abuse. Additionally, 63% of the shelters surveyed reported that children entering their shelters discussed incidents of companion animal abuse (Ascione et al., 1997).

Studies reviewed confirm that pet abuse by intimate partners is a common experience for women who are battered. If children are present, they are often exposed to pet abuse - an experience that may compromise their physical and mental health. Family pets may become pawns in a sometimes deadly form of coercion and terrorizing used by some batterers. Women's concerns about the welfare of their pets may be an obstacle to fleeing violence partners and may affect women's decision making about staying with, leaving, and/or returning to batterers (Ascione, 2007).

Domain G. Obsession with the Victim:

1. Stalking or monitoring (Campbell, 1995; Block, Campbell, & Tolman (2000)
2. Obsessive jealousy with the potential for violence, violently and constantly jealous, morbid jealousy (Wilson & Daly, 1992; Hilberman & Munson, 1978; Campbell et al., 2003)

Stalking

Stalking refers to repeated harassing or threatening behaviors that an individual engages in such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property. These actions may be accompanied by a credible threat of serious harm, and they may or may not be precursors to an assault or murder (Tjaden & Thoennes, 2000).

Stalking is a crime of intimidation. Stalkers harass and even terrorize through conduct that causes fear or substantial emotional distress in their victims. Stalking is defined as "the willful or intentional commission of a series of acts that would cause a reasonable person to fear death or serious bodily injury and, in fact, does place the victim in fear of death or serious bodily injury" (OVC, 2002).

Stalking is identified as a risk factor for both femicide and attempted femicide as research has demonstrated that stalking is revealed to be correlated with lethal and near lethal violence against women. Jacqueline Campbell's Danger Assessment lists violent and constant jealousy as a risk factor associated with homicide.

A study was undertaken to examine what factors predict the occurrence of stalking in relationships characterized by domestic violence, via in-depth interviews with victims of domestic violence whose cases had gone through the criminal justice system. The study found that the experience of stalking by the victims' abusers was very prevalent. In addition, victims who have experienced stalking within their relationships characterized by domestic violence are at a greater risk for experiencing more stalking (by their abuser) in the future (Melton, 2007).

A study was completed that described the frequency and type of intimate partner stalking that occurred within 12 months of attempted and actual partner femicide. One hundred forty-one femicide and 65 attempted femicide incidents were evaluated. The prevalence of stalking was 76% for femicide victims and 85% for attempted femicide victims. Incidence of intimate partner assault was 67% for femicide victims and 71% for attempted femicide victims. A statistically significant association exists between intimate partner physical assaults and stalking for femicide victims as well as attempted femicide victims. Stalking is revealed to be a correlate of lethal and near lethal violence against women and, coupled with physical assault, is significantly associated with murder and attempted murder. Stalking must be considered a risk factor for both femicide and attempted femicide (McFarlane et al., 1999).

Jealousy

Jealousy (as distinct from envy) refers to a complex mental state or "operating mode" activated by a perceived threat that a third party might usurp one's place in a valued relationship. It motivates any of various circumstantially contingent responses, ranging from vigilance to violence, aimed at countering the threat (Mullen & Martin, 1994).

Wilson and Daly (1996) report that battered women nominate “jealously” as the most frequent motive for their husbands/ assaults, and their assailants commonly make the same attribution. Wilson and Daly (1993) report the following: “Although wife beating is often inspired by a suspicion of infidelity, it can be the product of a more generalized proprietariness. Battered women commonly report that their husbands object violently to the continuation of old friendships, even with other women, and indeed to the wives’ having any social life whatever.

In a study of 60 battered wives who sought help at a clinic in rural North Carolina, (Hilberman & Munson, 1978) “found pathological jealousy to be a cornerstone to homicidal rage in their study of family violence in North Carolina.” They reported that the husbands exhibited morbid jealousy, such that leaving the house for any reason invariably resulted in accusations of infidelity that culminated in assault in 57 percent of the cases.

Domain H. Safety Concerns (The ultimate goal in reviewing and utilizing information is to protect the victim. Information shall not be used if it compromises victim and confidentiality - refer to Standard 5.04 II):

1. Victim perception of safety/victim concerned for safety (Gondolf, 2001; Klein, 2008; Buzawa, et al., 2000; ODARA, 2005; Heckert & Gondolf, 2004)
2. Victim (female victim in heterosexual relationship) believes offender is capable of killing her (Campbell, 1995)
3. Offender controls most of victim's daily activities (Campbell, 1995; Block, Campbell, & Tolman 2000; Tjaden & Thoennes, 2000)
4. Offender tried to "choke" victim (Campbell, 2008)
5. Physical violence is increasing in severity (Kropp & Hart, 2008; B-SAFER, 2005)
6. Victim forced to have sex when not wanted (Campbell, 1995)
7. Victim was pregnant at the time of the offense and offender knew this (Martin et al., 2001; ODARA, 2005)
8. Victim is pregnant and offender has previously abused her during pregnancy (Gazmararian, 1996; Martin et al., 2001)

Offender Controls

Several risk factors have been identified with homicide of battered women, which include offender's control of victim's daily activities and offenders' attempts to choke victim. Jacquelyn Campbell uses past incidences of strangulation as an indicator of abuse. Her research indicates that 84 of the 220 victims, or 57.1 % of homicide in her study regarding femicide had been killed by partners who had tried to "choke (strangle)" them at some time in their relationship (Campbell, 1995).

Offender Tried to Strangle Victim

In an analysis of the danger assessment risk factors, 15 or the 17 items distinguished intimate partner homicide victims from abused women. The factor with the third strongest risk (highest odds ration) was offender tried to choke (strangle) her. Those women were nine times more likely to be killed as other abused women (Campbell et al., 2004).

Physical Violence Increasing

It has long been observed that a pattern of recent escalation in the frequency or severity of assault is associated with imminent risk for violent recidivism. According to research done in the health care setting by Jacqueline Campbell, "The trajectory of the most severe kinds of abuse is often an increase in severity and frequency over time that may culminate in a homicide if the woman does not leave or the man does not receive treatment or is not incarcerated for violence" (Campbell & Boyd, 2003).

Forced Sex

Sexual assault or forced sex is another facet of approximately 40 to 45 percent of battering relationships. Sexual assault is defined as sexual acts coerced by physical force or threats or by power differentials. Two sample descriptive studies found battered women forced into sex by an intimate partner were also subject to more severe physical abuse and greater risk of homicide

(Campbell & Boyd, 2003).

Victim was Pregnant

Victims who are pregnant may suffer from more prevalent and severe abuse. “In several descriptive studies, battering during pregnancy has been associated with severe abuse, weapon carrying and threats by the abuser, and risk of homicide, suggesting that the man who beats his pregnant partner is an extremely dangerous man” (Campbell & Boyd, 2003).

One of the few qualitative data analyses related specifically to abuse during pregnancy, demonstrated that differing patterns of abuse occur during pregnancy according to the women abused. In a small percentage (15 percent) of the sample, women whose partners thought the baby was not his said their partners abused them most severely during pregnancy and seemed to be trying to cause a miscarriage. This is an important finding, given the link demonstrated in population-based studies between stepchildren and both female spouse and child homicide. Another group of women (19 percent), more likely to be in their first pregnancy, found their husbands to be jealous of their attachment to the unborn child. A third group (15 percent) said that the abuse was pregnancy specific but not related to the child. These two patterns may help explain the reports of some battered women who say the abuse first started or became exacerbated during pregnancy. However, the largest group of women (46 percent) reported that abuse during pregnancy was just a continuation of abuse that occurred before the pregnancy. This illustrates findings found in larger studies indicating that the major risk factor for abuse during pregnancy is abuse prior to pregnancy. This study also found that a substantial proportion of women (53 percent of a convenience sample of 61 battered women) were abused before and after pregnancy but not during pregnancy. The few larger studies that have looked at prevalence before and after pregnancy have also found this pattern (Campbell & Boyd, 2003).

A study was performed to identify risk factors for pregnancy-associated homicide (women who died as a result of homicide during or within 1 year of pregnancy) in the United States from 1991 to 1999. Pregnancy-associated homicides were analyzed with data from the Pregnancy Mortality Surveillance System at the Centers for Disease Control and Prevention. Six hundred seventeen (8.4%) homicide deaths were reported to the Pregnancy Mortality Surveillance System. The pregnancy-associated homicide ratio was 1.7 per 100,000 live births. Overall firearms (56.6%) were the leading mechanism of pregnancy-associated homicide. The study concluded that homicide is a leading cause of pregnancy-associated injury deaths (Chang, et al., 2005).

To describe the odds of femicide for women abused during pregnancy, a ten city case control design was used with attempted and completed femicides (n=437) and randomly identified abused women living in the same metropolitan area as controls (n=384). Abuse during pregnancy was reported by 7.8% of the abused controls, 25.8% of the attempted femicides, and 22.7% of the completed femicides. After adjusting for significant demographic factors, it was determined that the risk of becoming an attempted or completed femicide victim was three-fold higher (McFarlane, et al., 2002).

To determine the frequency, severity, and perpetrator of abuse during pregnancy as well as the occurrence of risk factors of homicide, an analysis was complete on African-American, Hispanic, and Anglo women in public health prenatal clinics. All women were assessed for abuse at the first prenatal visit and twice more during pregnancy. Prevalence of physical or sexual abuse during pregnancy was 16 percent (1 of 6). Abuse was recurrent, with 60 percent of the women reporting repeated episodes (McFarlane et al., 1996).

Victim's Perception of Safety

Weisz and colleagues performed a study from secondary data analysis comparing the accuracy of 177 domestic violence survivors' predictions of re-assault to risk factors supported by research. The item that was the single best predictor of severe violence was the women's perception of risk (Weisz, et al., 2000).

Gondolf and Heckert performed a study that partially replicated and expanded on a previous study that demonstrated women's perceptions of risk to be a strong predictor of re-assault among batterers. This study employed a multi-site sample, a follow-up period of 15 months, and multiple outcomes including repeated re-assault. The study's use of multinomial logistic regressions demonstrated how well women's perceptions of risk predict multiple outcomes and especially repeated re-assault (Gondolf & Heckert, 2004).

Domain I. Violence and/or Threatened Violence Toward Family Members Including Child Abuse (Does not include intimate partners):

1. Current or past social services case
2. Past assault of family members (Kropp & Hart, 2008)
3. Children were present during the offense (in the vicinity) (DVSI, 1998).

As defined by the SARA, family members include biological and legal relatives (parents, step-parents, siblings, etc.), as well as children from past or present intimate partners, but exclude past or present intimate partners. One of the most common research findings is that offenders with a history of violence are much more likely to engage in future violence than are those with no such history. Research has also demonstrated that wife assaulters who have a history of physical or sexual violence against family members are at increased risk for violent recidivism (Kropp & Hart, 2008).

Nationally, the reported rate of overlap between violence against children and violence against women in the same families is 30 to 60 percent. Although the studies on which this information is reported are based utilizing different methodologies (e.g., case record reviews, case studies, and national surveys), using different sample sizes, and examining different populations, they consistently report a significant level of co-occurrence (U.S. DHHS, 1999).

Child abuse and domestic violence often occur in the same family and are connected in many ways that may have serious consequences for the safety of all family members. Research shows that the impact on children of witnessing parental domestic violence is strikingly similar to the consequences of being directly abused by a parent. Many of the factors highly associated with the occurrence of child abuse are also associated with domestic violence (Carter, 2000).

The U.S. Department of Health, Education and Welfare reported that children from homes where the wife is battered are at a very high risk to receive their father's abuse. Research studies suggest links between child abuse and spousal abuse as evidenced by a study of 1,000 women (225 did not have children with the batterer). Those offenders who abused their spouses abused children in 70% of the families in which children were present. This study concluded that children of battered wives are very likely to be battered by their fathers and the severity of the spousal beating is predictive of the severity of child abuse (Yllo & Bograd, 1990).

Child abuse and domestic violence co-occur in an estimated 30 to 60 percent of the families where

there is some form of family violence according to a 2004 report by the Children's Defense Fund entitled *The State of America's Children 2004*.

The DVSI identifies "children present during the offense (in the vicinity)" as a factor in managing and predicting risk of future harm or lethality in domestic violence cases.

Domain J. Attitudes That Support or Condone Spousal Assault:

1. Explicitly endorses attitudes that support or condone intimate partner assault (Kropp & Hart, 2008; B-SAFER, 2005).
2. Appears to implicitly endorse attitudes that support or condone intimate partner assault (Kropp & Hart, 2008; B-SAFER, 2005).

Negative attitudes about spousal assault include beliefs and values that directly or indirectly encourage or excuse abusive, controlling and violent behavior. Such attitudes include sexual jealousy, misogyny, and patriarchy. Also included is minimization or denial of violent actions of the serious consequences of those actions (B-SAFER, 2002).

The SARA includes "attitudes that support or condone spousal assault" as a risk factor for repeated spousal violence because large-scale survey research, other empirical studies, and clinical observation suggest that a number of sociopolitical, religion, cultural, and personal attitudes differentiate between men who have recently assaulted their partners and those who have not. A common thread running through these attitudes is that they support or condone wife assault implicitly or explicitly. Such attitudes often co-exist with minimization/denial of wife assault, and are associated with increased risk of violent recidivism (Kropp & Hart, 2008).

Domain K. Prior Completed or Non-completed Domestic Violence Treatment:

- (DVSI, 1998; Hisashima, 2008; Stalans et al., 2004)

Prior domestic violence treatment or counseling whether mandated or voluntary is an item included on the Domestic Violence Screening Instrument (DVSI). A validation study of the DVSI was recently completed by the Hawaii State Department of Health. This analysis indicated that prior domestic violence treatment was reported in 24.9% of the assessments. This study concluded that the DVSI analyses indicate that the instrument is accurately classifying offenders based on risk (Hisashima, 2008)

A study funded by the Illinois Criminal Justice Information Authority addressed whether three groups of violent offenders have similar or different risk factors for violent recidivism while on probation. It concluded that for generalized aggressors and family only batterers, treatment compliance was an important risk predictor of violent recidivism (Stalans et al., 2004).

Domain L. Victim Separated from Offender Within the Previous Six Months:

- (DVSI, 1998; Hisashima, 2008; Wilson & Daly, 1993; Campbell, et al., 2003)

The DVSI defines separation as the following: (1) physical separation (2 going into shelter, moving out, moving in with friends, or evicted by the defendant. In a validation study of the DVSI based on all DVSI assessments completed by the State of Hawaii between August 2003 and July 2007, victims separated from offenders within the previous six months represented the second most commonly

reported risk factor (38.5%).

An examination of uxoricide (murder of one's wife) in Canada reported that if violence or threats of violence are used as a way to limit female autonomy, men may be motivated to act in these ways in response to probabilistic cues of their wives' likelihood or intention of desertion. It follows that resolving to leave one's husband may be associated with elevated risk of violence, including risk of being killed (Wilson, et al., 1993). The results of a multi-site case control study concluded that "the risk of intimate partner femicide was increased nine-fold by the combination of a highly controlling abuser and the couple's separation after living together" (Wilson et al., 1993).

Domain M. Unemployed

- (DVSI, 1998; Kyriacou, et al., 1999; Campbell, et al., 2003; Benson & Fox, 2004; B-SAFER, 2005)
- Unemployed is defined as not working at time of the offense or at any time during intake or treatment and does not include offenders on public assistance, homemakers, students, or retirees

Unemployment has been shown to be an important risk factors used for predicting intimate partner femicide. In a study that compared femicide perpetrators with other abusive men, the conclusion was that unemployment was the most important demographic risk factor for acts of intimate partner femicide. In fact, an abuser's lack of employment was the only demographic risk factor that significantly predicted femicide risks (Campbell et al., 2003).

In a validation study of the DVSI based on all DVSI assessment completed between August 2003 and July 2007 by the State of Hawaii, unemployment represents the fourth (35.4%) most commonly reported risk factor (Hisashima, 2008).

The Level of Supervision Inventory (LSI) Criminal History Scale identifies job stability as a major factor in reducing recidivism. "A history of poor job performance and attitude signifies disregard for pro-social reinforcements. Lack of consistent employment reflects a higher risk for return to criminal lifestyle." (Andrews & Bonta, 2005).

Domain N. Absence of Verifiable Pro-social Support System.

1. Some criminal acquaintances

The presence of some criminal acquaintances is associated with an opportunity for pro-criminal modeling, a concept that is considered a major risk factor (Andrews & Bonta, 2005)

AND

1. Some criminal friends

Attachments to pro-criminal others is a well documented predictor of criminal behavior, with roots in both of the major explanatory theories in criminology: social control and social learning (Andrews & Bonta, 2005).

"Uncaring, negative, or hostile relationships with relatives who have frequent contacts are indicative of poor social and problem-solving skills and a lack of pro-social modeling. Criminal family member(s) indicate negative modeling and exposure to pro-criminal influence and/or vicarious reinforcement of anti-social attitude and behaviors. The lack of anti-criminal companions indicates two things: first, there is less of an opportunity to observe pro-social models, and secondly, there is an absence of companions who can actively reinforce pro-social behavior and punish undesirable behavior.

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Domestic Violence Risk and Needs Assessment (DVRNA)

Scoring Manual

Second Edition 2010



Domestic Violence Offender Management Board
Division of Criminal Justice
Colorado Department of Public Safety
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Overview and Administration

Introduction

The Domestic Violence Risk and Needs Assessment (DVRNA) was developed by the Treatment Review Committee (Committee) of the Colorado Domestic Violence Offender Management Board (DVOMB). The Domestic Violence Risk and Needs Assessment (DVRNA) is a risk assessment for adult domestic violence offenders 18 years and older. It is intended to be completed once all the evaluation data has been gathered. It is empirically based and has content and face validity. The DVOMB has obtained funding for a validation study which will begin in October 2010.

This instrument was designed to identify risk factors that should be considered when working with domestic violence offenders in treatment. It is only intended to be used for offenders who have been arrested and are in the criminal justice system for a domestic violence offense. The risk factors that are empirically based on this instrument are predictive for offenders in the criminal justice system. It aids in determining appropriate level of treatment intensity. The DVRNA presents a framework within which to assess the risk of future intimate partner violence for domestic violence offenders in treatment. The DVRNA takes numerous risk factors that have been identified through empirical research as increasing the risk of violence or escalating its seriousness and consolidates these factors into a single measure, thus providing a method of determining the likelihood (probability) of ongoing or repeat violence.

Description

The DVRNA is composed of 14 domains of risk most highly predictive of future violence, which were selected based on an extensive literature review, the clinical experience of the Committee, and the knowledge from the criminal justice system participants. Many items concern an offender's criminal history. A few domains are dynamic in nature, such as current lifestyle stability factors. Risk factors are used as one measure to assist with initial treatment planning including the design of offender competencies, and ongoing treatment plan reviews.

The DVRNA is a risk assessment tool that assigns offenders a total score based on risk for repeated domestic violence. Thus, an offender may be placed into one of three categories of intensity of treatment; low, moderate, or high. For example, any indication of a Significant Risk Factor would require initial treatment placement in the moderate level at a minimum, while an indication of a Critical Risk Factor would require initial treatment placement in the high intensity level.

User Qualifications and Training

The DVRNA was designed to be scored easily by treatment providers in conjunction with the Multi-disciplinary Treatment Team, made up of an Approved Provider, responsible criminal justice agency, and a treatment victim advocate at a minimum. Other professionals relevant to a particular case may also be a part of the MTT such as human services, child welfare, and child protection services. Before using this assessment, it is important to read this manual and the Annotated DVRNA. In addition, users should complete DVOMB training because it is critical to insure rater accuracy and fidelity to the instrument. DVRNA users should have a basic understanding of risk factors related to domestic violence recidivism.

Documentation of Information Sources

When completing the DVRNA for each domain, it is essential to identify the sources utilized to obtain the information. It is preferable to use official records (e.g., mental health, criminal justice reports), credible offender reports and written collateral reports for this documentation. The scoring of the instrument is intended to be transparent and sources of information must be available.

Scoring Instructions ***Domain Risk Items***

A: Prior Domestic Violence Related Incidents (Any of the following are Significant Risk Factors that indicate initial treatment in Level B except number 1, which is a Critical Risk Factor and indicates treatment in Level C.

This domain applies only to adult criminal history
Do not include offenses committed as a juvenile

1. Prior domestic violence conviction

Critical Risk Factor that indicates initial treatment placement in Level C.

Include self reports of convictions

Includes deferred judgments, guilty pleas

Include convictions identified in criminal history as reported by probation or criminal justice report

2. ***Violation*** of an order of protection (documented)

Include civil or criminal protection orders

Include past or current orders

Include temporary protection orders

Include alcohol violations

3. Past or present civil domestic violence related protection orders against offender

Does not include criminal protection orders related to the arrest and conviction.

Do not include automatic orders related to marriage dissolution

Include temporary and permanent orders

4. Prior arrests for domestic violence

Include any arrest as an adult that was identified in the arrest as domestic violence

5. Prior domestic violence incidents not reported to criminal justicesystem

Include incidents reported by the victim ***only*** if the victim gives written permission to include this in the scoring of the DVRNA.

Include offender self report of incidents

Include any incident commencing after age 18

Include incidents involving any intimate partner after age 18

Include incidents reported in writing by collateral contacts or documented interview(s).

Domain B: Drug or Alcohol Abuse (Any of the following are Significant Risk Factors that indicate initial treatment in Level B).

Requires use of a Division of Behavioral Health approved screening or assessment instrument and/or self-report or recent illegal activity involving substance abuse with emphasis on the most recent 12 months.

No problem indicates that there is no alcohol or drug abuse or that alcohol or drugs do not interfere with the offender's functioning.

1. Substance abuse/dependence within the previous 12 months

Refer to the DSM-IV-TR (or current version) for substance dependence or abuse criteria.

2. History of substance abuse treatment within the previous 12 months, or two or more prior drug or alcohol treatment episodes during adult lifetime.

Include any court-ordered or voluntary substance abuse treatment or counseling.
Include offender self-report

3. Offender uses illegal drugs or illegal use of drugs

Colorado Revised Statutes Section 18-18-404(1) refers to "unlawful use of a controlled substance - using any controlled substance, except when it is dispensed by or under the direction of a person licensed or authorized by law to prescribe, administer, or dispense such controlled substance for bona fide medical needs."

Illegal use of drugs includes the abuse of prescription medication; abuse of over-the-counter drugs; and or using illegal drugs such as cocaine, heroin, LSD, methamphetamine, etc.

Tobacco is not included

You may use offender self-report, police report, criminal justice record, and other witnesses.

Discussion Point: For offenders that report the use of medical marijuana:

If the Approved Provider has verified the offender has a Colorado approved medical marijuana certificate AND the court or supervising agent for the court is allowing the offender to use the medical marijuana while under court supervision, then DO NOT score this as an illegal use of a substance.

Note: This does not prohibit an Approved Provider from also determining as necessary whether the marijuana use is being abused by the offender. If approved assessment instruments and evaluation identify that the marijuana is being abused, than this is scored under number 1.

If the Approved Provider verifies that the offender does not have a Colorado approved medical marijuana certificate AND the court or supervising agent for the court is NOT allowing the offender to use the medical marijuana while under court supervision, then score this as illegal use of a substance.

Domain C: Mental Health Issue (Any of the following are Significant Risk Factors that indicate initial treatment placement in Level B at a minimum).

Mental health concerns may be documented from offender self-report, from the diagnosis by a qualified Approved Provider, from medical records, or from a practitioner qualified to identify a disorder. If an Approved Provider is not qualified to assess the mental health of an offender, the offender may need to be referred to a qualified clinician.

1. Existing Axis I or II diagnosis excluding V codes

The V code section of the DSM-IV-TR deals with other conditions that may be a focus of clinical attention. V codes are not a diagnosis and therefore not scored. Do not score a substance abuse/dependence if this has already been scored on Domain B Drug or Alcohol Abuse.

2. Personality disorder with anger, impulsivity, or behavior instability (SARA, 2008)

This item should be ascertained based on past or current mental health evaluations. If an Approved Provider is not qualified to assess personality disorders, he/she needs to refer to an Approved Provider who is qualified or another qualified clinician.

Refer to the DSM-IV-TR (or current version)

3. Severe psychopathology

Psychopathy is a risk for violent behavior. It is a criminal justice construct. It is not defined in the DSM-IV-TR, subsequently you cannot diagnose someone as a psychopath. However, the degree of someone's psychopathy can be used as a risk factor (HARE Psychopathy Checklist Revised-providers must be trained in the use of this tool).

4. Recent psychotic and/or manic symptoms (SARA, 2008)

"Recent" is defined as the previous 12 months

Psychotic symptoms may include (a) grossly disorganized or illogical speech, (b) delusions, (c) hallucinations, and (d) grossly bizarre behavior. Manic symptoms include (a) extreme euphoria or irritability, (b) grandiosity, (c) racing thought and pressured speech, and (d) motoric hyperactivity

5. Psychological/psychiatric condition currently unmanaged

This condition needs to be diagnosed by a medical or health care clinician, by medical records, or by offender self-report.

6. Non-compliance with prescribed medications and mental health treatment

This information should be obtained from offender self-report or medical records.

7. An offender exhibits symptoms that indicate the need for a mental health evaluation

These symptoms may include such indicators as possible depression, psychosis, mania, and/or anxiety.

Domain D: Suicidal/homicidal

1. Serious homicidal or suicidal ideation/intent within the past year

“Serious” as defined in the SARA means that the ideation is experienced as persistent and intrusive or involves high lethality methods; or that the level of intent is moderate to high.

This is a Critical Risk Factor that indicates initial treatment in Level C.

2. Ideation within the past 12 months

The term suicidal/homicidal ideation generally refers to thoughts of committing homicide/ suicide, including planning how it will be accomplished.

May be obtained from offender self-report or documented by other clinicians

3. Credible threats of death within the past 12 months

“Credible” means that the threats were perceived as credible by the victim (SARA, 2008)

4. Victim reports offender has made threats of harming/killing her

If the information is revealed by a discussion with the victim, protection of the victim is priority. It is imperative that if the victim signs a release that allows this information to be utilized for scoring the DVRNA, she/he understands the ramifications of signing such a form, possible retaliation from an offender and has received safety planning assistance from the treatment victim advocate.

When a victim states that his/her information cannot be revealed beyond the Approved Provider, the Approved Provider and the victim advocate, without compromising victim confidentiality, may consult with probation and shall ascertain other potential ways to document or address victim concerns. *For example:* If the victim reports substance abuse by the offender, the Approved Provider may require random urinalysis, thus obtaining information without revealing victim information.

Domain E: Use and/or threatened use of weapons in current or past offense or access to firearms

This information can be documented utilizing offender self-report, reports from probation, collateral reports, or police reports.

Use and/or threatened use of weapons include the threat or actual use of any weapon that poses potential realistic physical harm to the victim’s life. Potentially deadly weapons may include firearms, knives, and objects used as clubs; or such objects as tools, phones, etc. The object should not be a body part (e.g., hands, feet, mouth).

1. Gun in the home in violation of a civil or criminal court order

This is a Critical Risk Factor that indicates initial treatment in Level C

2. Use and/or threatened use of weapons in current or past offense

This is a Critical Risk Factor that indicates initial treatment in Level C

This information may be obtained from the police report and/or victim statements. If the information is revealed by a discussion with the victim, protection of the victim is priority. It is imperative that the if the victim signs a release that allows this information to be utilized for scoring the DVRNA, she/he understands the ramifications of signing such a form, possible retaliation from an offender, and has received safety planning assistance from the treatment victim advocate.

3. Access to firearms

Includes personal ownership of a firearm or living in a household with a firearm

Do not score if the offender does not have access to firearms - for example if they are stored or locked elsewhere outside the home.

If a court order is allowing the offender to have a weapon, this is still scored because the offender has access to a weapon.

Domain F: Criminal history - nondomestic violence (both reported and unreported to criminal justice system.

This information may be documented from probation reports, arrest records, or offender self-report.

This domain applies only to adult criminal history

1. Offender was on community supervision at the time of the offense

This is a Critical Risk Factor that indicates initial treatment in Level C

Community supervision includes supervised probation, unsupervised (court monitored) probation, parole, private probation, community corrections, pre-trial release, bond, etc.

2. Offender has a prior arrest for assault, harassment, or menacing

If there have been two or more arrests, this is a Significant Risk Factor that indicates initial treatment in Level B at a minimum.

Do not include a domestic violence enhanced crime

3. Prior nondomestic violence convictions at any time during offender's adult life

Include any municipal, misdemeanor, and felony convictions.

Includes all convictions except traffic violations

NOTE: IF the offender was scored on Domain B 2 only for two or more prior drug or alcohol treatment episodes during his/her lifetime DO NOT also score any related previous DUIs here.

4. Past violation(s) of conditional release or community supervision

“Conditional release” includes probation, parole, bail, conditional discharge, suspended sentence, or any other occasion in which the offender is at liberty in the community under supervision or other requirements ordered by the court.

Violation of a no contact order counts as violation of conditional release

5. Past assault of strangers, or acquaintances

Assault includes physical assault, sexual assault and any use of a weapon.
There does not have to be an arrest to code this item.
Document how the information was obtained

6. Animal cruelty/abuse

Includes threatening, abusing, or killing a family pet.
There does not have to be an arrest to code this item.
Document how the information was obtained

Domain G: Obsession with the victim (Current victim or current partner only)

1. Stalking or monitoring

Stalking, as defined by the National Center for Victims of Crime, Stalking Resource Center, is a pattern of repeated, unwanted attention, harassment, and contact. It is a course of conduct that can include:

- Following or laying in wait for the victim
- Repeated unwanted, intrusive, and frightening communications from the perpetrator by phone, mail, and/or e-mail
- Damaging the victim’s property
- Making direct or indirect threats to harm the victim, the victim’s children, relatives, friends, or pets
- Repeatedly sending the victim unwanted gifts
- Harassment through the Internet, known as cyberstalking, online stalking, or Internet stalking
- Securing personal information about the victim by: accessing public records (land records, phone listings, driver or voter registration), using Internet search services, hiring private investigators, contacting friends, family, work, or neighbors, going through the victim’s garbage, following the victim, etc.

2. Obsessive jealousy with the potential for violence, violently and constantly jealous, or morbid jealousy.

- Morbid jealousy describes a range of irrational thoughts and emotions, together with associated unacceptable or extreme behavior, in which the dominant theme is a preoccupation with a partner’s sexual unfaithfulness based on unfounded evidence.
- Individuals may suffer from morbid jealousy even when their partner is being unfaithful, provided that the evidence that they cite for unfaithfulness is incorrect and the response to such evidence on the part of the accuser is excessive or irrational.
- Morbidly jealous individuals interpret conclusive evidence of infidelity from irrelevant occurrences, refuse to change their beliefs even in the face of conflicting information, and tend to accuse the partner of infidelity with many others.

This domain could be scored with evidence of a protection order that is based on stalking or a

violation of that type of protection order. A charge for stalking with the current victim would also result in a score on this item.

If the offender was scored for a civil protection order under Domain A.3 and the protection order is due to stalking, also score this Domain.

Domain H: Safety concerns

Information should not be used if it compromises victim safety and confidentiality and if the victim has not signed a written release of information specifically related to what information the victim is sharing. It is imperative that if the victim signs a release that allows this information to be utilized for scoring the DVRNA, she/he understands the ramifications of signing such a form, possible retaliation from an offender, and has received safety planning assistance from the treatment victim advocate. If the information is in the police report, the victim need not sign a release or give permission for this information to be used.

1. Victim perception of lack of safety/victim concerned for safety
2. Victim (female victim in heterosexual relationship) believes offender is capable of killing her
NOTE: Even though threats of death are only scored for male offender against female victim, the MTT shall consider threats of death by the offender toward the victim regardless of gender and over ride the findings of the DVRNA if necessary.
3. Offender controls most of victim's daily activities

4. Offender tried to "choke" victim

Although the medical terminology is "strangle", victims more readily identify with the word choke when reporting abuse.

5. Physical violence is increasing in severity
6. Victim forced to have sex when not wanted
7. Victim was pregnant at the time of the offense and offender knew this.
8. Victim is pregnant and offender has previously abused her during pregnancy.

Domain I: Violence and/or threatened violence toward family members including child abuse

This does not include criminal history. If there is criminal history related to this/these incident(s), score only on Domain F, number 3.

1. Current or past social services case as an adult where the offender was party to the action.
Voluntary social services involvement is not scored. This item is intended to be open or past cases in social services.
2. Past assault of family members

"Assault" includes physical assault, sexual assault, and any use of a weapon.

"Family members" include biological and legal relatives (parents, step-parents, siblings, etc.), as well as children by previous or present intimate partners.

Excludes previous or present intimate partners.

Score even if there was no arrest conviction.

May be obtained from credible offender self-report and written collateral reports.

3. Children were present during the offense (in the vicinity)

A yes response would include any children in the home or location of offense even if they were sleeping, or it was perceived that they could not hear or see the offense.

Include all children under of age of 18 regardless of their relationship to the victim and offender.

Domain J: Attitudes that support or condone spousal assault

Support or condone either implicitly or explicitly, by encouraging (a) patriarchy (male prerogative), (b) misogyny, and/or (c) the use of violence to resolve conflicts.

Multiple arrests for domestic violence **do not** implicitly or explicitly imply attitudes that support or condone spousal assault.

1. Explicitly endorses attitudes that support or condone intimate partner assault

Explicit endorsed attitudes can be identified because they are precisely and clearly expressed or readily observable, leaving nothing to implication. It is expressed in a clear and obvious way, leaving no doubt as to the intended meaning.

Examples include: offender calling the victim by derogatory names, stating that the victim/partner should obey the offender, lack of obedience is justification for abuse, stating that the victim is too stupid to handle money.

2. Appears to implicitly endorse attitudes that support or condone intimate partner assault.

Implicit endorsed attitudes are suggested or understood without being directly stated. To imply is to suggest rather than to state. An action or incident can imply an idea that would otherwise have to be stated.

Examples include: offender justifies behaviors that indicate the victim provoked him; such as she wouldn't stop talking or she was drunk. Offender provides covert messages around his/her true beliefs. Offender may verbally say he/she would not abuse his/her partner, but he/ she is controlling and abusive by the actions of his/her behaviors.

Domain K: Prior completed or non-completed domestic violence treatment

Treatment occurred at any time in the past and was not completed, regardless of reason.

This information may be obtained from an Approved Provider or credible offender self-reports and written collateral reports from the criminal justice system.

Prior treatment that occurred at **any** time in the past regardless of the type of discharge received, whether successful, unsuccessful, or administrative.

Include any court-ordered or voluntary domestic violence treatment or counseling.

Domain L: Victim separated from offender within the previous six (6) months

This refers to the risk of separation and is scored based on the victim separating from the offender within six months prior to the offense. Score this only when the victim has chosen to separate. This does not include the offender separating or a court order that requires they separate. Also score this item if the victim left and returned to the abuser.

It is a risk factor that can be reviewed at time of evaluation and calculated as the six (6) months previous to the evaluation.

Additionally, any time the victim initiates a separation from the offender this is a risk and needs to be scored and taken into consideration by the MTT. The MTT will determine on a case by case basis if the victim leaves during the offender's treatment whether this will impact level of treatment or treatment planning.

Separation refers to physical separation.

Separation may include entering a shelter, moving out of the residence, moving in with friends, or eviction of the offender.

Domain M: Unemployed

Do not count employment that is criminal in nature (e.g. drug dealing).

Unemployed is defined as not working at time of offense or at any time during intake or treatment and does not include offenders on public assistance, homemakers, students, or retirees.

An offender that is unemployed and collecting unemployment is scored as unemployed.

Domain N: Involvement with people who have pro-criminal influence

In order to score one point in this domain, both of the following factors shall be present.

1. Some criminal acquaintances

The presence of some criminal acquaintances is associated with an opportunity for pro-criminal modeling, a concept that is considered a major risk factor (Andrews & Bonta, 1994; Gendreau, 1995; Elliot et al., 1987; Hawkins & Lam, 1987).

Explore the scope of criminal involvement of the individual's network and to what degree it is an accepted norm.

- Score if the individual associates with (or did associate with prior to incarceration) some individuals who are not close friends, but are known to have criminal records or are known to be involved in criminal activity.
- Potential questions that can be asked: "Of the friends you just mentioned (reiterate by name if possible) which ones have been in trouble with the law, as far as you are aware?"

For acquaintances or friends that have criminal records but are now clearly pro-social and stable, e.g., NA or AA sponsor with several years clean and sober, do not count these individuals as a pro-criminal influence

AND

2. Some criminal friends

Attachments to pro-criminal others is a well documented predictor of criminal behavior, with roots in both of the major explanatory theories in criminology: social control (Hirschi, 1969) and social learning (Akers & Burgess, 1968).

Inquire whether the offender's friends are known to be involved in unlawful behavior. Potential questions that can be utilized are: "You've indicated____and____and____are friends of yours. What kind of experience have they had with criminal behavior?"

Explore the criminal orientation (to what degree they participate or support unlawful activities) of the individual's friends.

- Score if the individual has friends (or did prior to incarceration) who are known to have criminal records or are known to be involved in criminal activity.
- Friends are associates with whom one spends leisure time, whose opinions are valued, who provide help when in difficulty, etc.

Domestic Violence Risk & Needs Assessment (DVRNA)

Scoring Sheet

Name: _____ Client Number: _____ Date: _____

Client date of birth: _____ Client SSN: _____ Client State ID: _____

Supervising Agency/Officer: _____ Case: _____

***THIS IS A REQUIRED FORM.
ONLY SCORE INFORMATION RELATED TO THE OFFENDER AS AN ADULT.***

A. Prior domestic violence related incidents		<u>Yes</u>
1. Prior domestic violence conviction: Critical Risk Factor—Level C		<input type="checkbox"/>
Any of the following are Significant Risk Factor—Level B (minimum)		<u>Yes</u>
2. Violation of an order of protection (documented violation).....	<input type="checkbox"/>	<input type="checkbox"/>
3. Past or present civil domestic violence related protection orders against offender...	<input type="checkbox"/>	
4. Prior arrests for domestic violence.....	<input type="checkbox"/>	
5. Prior domestic violence incidents not reported to criminal justice system.....	<input type="checkbox"/>	
Information Sources: _____ Domain A—Criteria Met.....		
Identify Level B or Level C _____		

B. Drug or alcohol abuse		<u>Yes</u>
Any of the following are Significant Risk Factor—Level B (minimum)		<u>Yes</u>
1. Substance abuse/dependence within the past 12 months.....	<input type="checkbox"/>	<input type="checkbox"/>
2. History of substance abuse treatment within the past 12 months or 2 or more prior drug or alcohol treatment episodes during lifetime.....	<input type="checkbox"/>	
3. Offender uses illegal drugs or illegal use of drugs.....	<input type="checkbox"/>	
Information Sources: _____ Domain B—Criteria Met.....		<input type="checkbox"/>
Level B _____		

C. Mental health issue		<u>Yes</u>
Any of the following are Significant Risk Factor—Level B (minimum)		<u>Yes</u>
1. Existing Axis I or II diagnosis (excluding V codes).....	<input type="checkbox"/>	
2. Personality disorder with anger, impulsivity, or behavioral instability.....	<input type="checkbox"/>	
3. Severe psychopathology.....	<input type="checkbox"/>	
4. Recent psychotic and/or manic symptoms.....	<input type="checkbox"/>	
5. Psychological/psychiatric condition currently unmanaged.....	<input type="checkbox"/>	
6. Noncompliance with prescribed medications and mental health treatment.....	<input type="checkbox"/>	
7. Exhibiting symptoms that indicate the need for a mental health evaluation.....	<input type="checkbox"/>	
Information Sources: _____ Domain C—Criteria Met.....		<input type="checkbox"/>
Level B _____		

D. Suicidal/homicidal		<u>Yes</u>
1. Serious homicidal or suicidal ideation/intent within the past year: Critical Risk Factor—Level C.....	<input type="checkbox"/>	
	<u>Yes</u>	
2. Ideation within the past 12 months.....	<input type="checkbox"/>	
3. Credible threats of death within the past 12 months.....	<input type="checkbox"/>	
4. Victim reports offender has made threats of harming/killing her (female victims in heterosexual relationships).....	<input type="checkbox"/>	
Information Sources: _____ Domain D—Criteria Met.....		<input type="checkbox"/>
Level C _____		

E. Use and/or threatened use of weapons in current or past offense or access to firearms.		<u>Yes</u>
1. Gun in the home in violation of a civil or criminal court order Critical Risk Factor--Level C.....	<input type="checkbox"/>	
2. Use and/or threatened use of weapons in current or past offense Critical Risk Factor--Level C.....	<input type="checkbox"/>	
	<u>Yes</u>	
3. Access to firearms.....	<input type="checkbox"/>	
Information Sources: _____ Domain E—Criteria Met.....		<input type="checkbox"/>
Level C _____		

F. Criminal history-nondomestic violence (both reported and unreported to criminal justice system). This domain applies only to adult criminal history.		<u>Yes</u>
1. Offender was on community supervision at the time of the offense: Critical Risk Factor–Level C.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Offender has a prior arrest for assault, harassment, or menacing. If there have been two or more: Significant Risk Factor--Level B (minimum).....	<input type="checkbox"/>	
	<u>Yes</u>	
3. Prior nondomestic violence convictions.....	<input type="checkbox"/>	
4. Past violations of conditional release or community supervision.....	<input type="checkbox"/>	
5. Past assault of strangers, or acquaintances.....	<input type="checkbox"/>	
6. Animal cruelty/abuse.....	<input type="checkbox"/>	
Information Sources: _____ Domain F–Criteria Met.....		<input type="checkbox"/>
Identify Level B or Level C _____		

G. Obsession with the victim		<u>Yes</u>	<u>Yes</u>
1. Stalking or monitoring.....	<input type="checkbox"/>	<input type="checkbox"/>	
2. Obsessive jealousy with the potential for violence, violently and constantly jealous, morbid jealousy.....	<input type="checkbox"/>		
Information Sources: _____ Domain G–Criteria Met.....			<input type="checkbox"/>

H. Safety concerns		<u>Yes</u>	<u>Yes</u>
The ultimate goal in reviewing and utilizing information is to protect the victim. Information shall not be used if it compromises victim safety and confidentiality. (Refer to Standard 5.04 II)			
1. Victim perception of safety/victim concerned for safety.....	<input type="checkbox"/>	<input type="checkbox"/>	
2. Victim (female victim in heterosexual relationship) believes offender is capable of killing her.....	<input type="checkbox"/>		
3. Offender controls most of victim’s daily activities.....	<input type="checkbox"/>		
4. Offender tried to “choke” victim.....	<input type="checkbox"/>		
5. Physical violence is increasing in severity.....	<input type="checkbox"/>		
6. Victim forced to have sex when not wanted.....	<input type="checkbox"/>		
7. Victim was pregnant at the time of the offense and offender knew this.....	<input type="checkbox"/>		
8. Victim is pregnant and offender has previously abused her during pregnancy.....	<input type="checkbox"/>		
Information Sources: _____ Domain H–Criteria Met.....			<input type="checkbox"/>

<p>I. Violence and/or threatened violence toward family members, including child abuse (does not include intimate partners)</p> <p>1. Current or past social services case(s) 2. <input type="checkbox"/></p> <p>Past assault of family members..... 3. <input type="checkbox"/></p> <p>Children were present during the offense..... <input type="checkbox"/></p> <p>Information Sources: _____ Domain I—Criteria Met.....</p>	<p><u>Yes</u></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><u>Yes</u></p> <p><input type="checkbox"/></p>
<p>J. Attitudes that support or condone spousal assault</p> <p>1. Explicitly endorses attitudes that support or condone intimate partner assault..... <input type="checkbox"/></p> <p>2. Appears to implicitly endorse attitudes that support or condone intimate partner assault..... <input type="checkbox"/></p> <p>Information Sources: _____ Domain J—Criteria Met.....</p>	<p><u>Yes</u></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><u>Yes</u></p> <p><input type="checkbox"/></p>
<p>K. Prior completed or noncompleted domestic violence treatment</p> <p>Information Sources: _____ Domain K—Criteria Met.....</p>	<p><input type="checkbox"/></p>	<p><u>Yes</u></p> <p><input type="checkbox"/></p>
<p>L. Victim separated from offender within the previous six months.</p> <p>Information Sources: _____ Domain L—Criteria Met.....</p>	<p><input type="checkbox"/></p>	<p><u>Yes</u></p> <p><input type="checkbox"/></p>
<p>M. Unemployed</p> <p>Unemployed is defined as not working at time of offense or at any time during intake or treatment and does not include offenders on public assistance, homemakers, students, or retirees.</p> <p>Information Sources: _____ Domain M—Criteria Met.....</p>	<p><input type="checkbox"/></p>	<p><u>Yes</u></p> <p><input type="checkbox"/></p>
<p>N. Involvement with people who have pro-criminal influence</p> <p>1. Some criminal acquaintances..... <input type="checkbox"/></p> <p>AND</p> <p>2. Some criminal friends..... <input type="checkbox"/></p> <p>Information Sources: _____ Domain M—Both Criteria Met.....</p>	<p><u>Yes</u></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><u>Yes</u></p> <p><input type="checkbox"/></p>

*Colorado Domestic Violence Offender Management Board
Standards and Guidelines for Domestic Violence Offenders*

Risk Criteria	Met		<u>Significant/Critical Risk Criteria</u>	<u>Met</u>
A	<input type="checkbox"/>	➔	Level B or C? _____	<input type="checkbox"/>
B	<input type="checkbox"/>	➔	Level B.....	<input type="checkbox"/>
C	<input type="checkbox"/>	➔	Level B.....	<input type="checkbox"/>
D	<input type="checkbox"/>	➔	Level C? _____	<input type="checkbox"/>
E	<input type="checkbox"/>	➔	Level C? _____	<input type="checkbox"/>
F	<input type="checkbox"/>	➔	Level B or C? _____	<input type="checkbox"/>
G	<input type="checkbox"/>			
H	<input type="checkbox"/>			
I	<input type="checkbox"/>			
J	<input type="checkbox"/>			
K	<input type="checkbox"/>			
L	<input type="checkbox"/>			
M	<input type="checkbox"/>			
N	<input type="checkbox"/>			
Total Score				

Level A = 0 - 1 risk factors met
 Level B = 2 - 4 risk factors met
 Level C = 5 or more risk factors met

<u>Level Recommended</u>			<u>Level Placed</u>		
A	B	C	A	B	C
<input type="checkbox"/>					

Comments: _____

Override Reasons:

Information Source Codes

- | | |
|---|---|
| 1. Offender self-report | 6. Child Protection or Social Services records |
| 2. Law Enforcement Report (Police Reports) | 7. Public Victim Report/Victim Impact Statement |
| 3. Criminal History | 8. Prison Record |
| 4. Mental Health Evaluation/Assessment | 9. Pre-Sentence Report |
| 5. Substance Abuse Evaluation/Assessment/Screen | 10. Probation Information Report |

11. Other: _____

Document or Verify Consensus of MTT (this does not require a signature)

Evaluator _____ Date _____

Probation _____ Date _____

Victim's Advocate _____ Date _____

Appendix H: Guidelines for Promoting Healthy Sexual Relationships Adopted 10/11/2013

I. Introduction

The following guidelines have been developed to address the issue of interpersonal sexual violence than can accompany domestic violence. The purpose of these guidelines is to help identify resources for treatment providers that can be used throughout offender treatment that promotes appropriate intimacy and communication. These guidelines supplement the DVOMB *Standards and Guidelines* and are found in the Appendix B of the Standards. The DVOMB expresses its appreciation to the Sexual Abuse Competencies Committee for the development of this document.

The DVOMB recognizes that the issue of promoting healthy sexual relationships is not a stand-alone competency but rather touches on a number of competencies. As such, the weaving of healthy sexuality throughout treatment is emphasized.

II. Related Competencies:

Excerpted from DVOMB *Standards and Guidelines*. PLEASE NOTE: Promoting healthy sexual relationships can be added to and explored along with any of these competencies at a minimum.

5.8 V. Offender Core Competencies

- A. Offender commits to the elimination of abusive behavior
 - 1. Eliminates the use of physical intimidation, psychological cruelty, or coercion toward one's partner or children
- B. Offender development of empathy
 - 1. Recognizes and verbalizes the effect of one's actions on one's partner/victim
- C. Offender accepts full responsibility for the offense and abusive history
 - 1. Discloses the history of physical and psychological abuse towards the offender's victim(s) and children
 - 2. Overcomes the denial and minimization that accompany abusive behavior.
 - 3. Makes increasing disclosures over time
 - 4. Accepts responsibility for the impact of one's abusive behavior on secondary, tertiary victims, and the community
 - 5. Recognizes that abusive behavior is unacceptable.
- D. Offender identifies and progressively reduces pattern of power and control behaviors, beliefs, and attitudes of entitlement.
 - 1. Identifies the specific forms of day-to-day abuse and control, such as isolation that have been utilized, as well as the underlying outlook and excuses that drove those behaviors.
- E. Offender Accountability
 - 1. Recognizes and eliminates all minimizations of abusive behavior.
- F. Offender ability to define types of domestic violence
- G. Offender Accountability
 - 1. Recognizes and eliminates all minimizations of abusive behavior.
- H. Offender ability to define types of domestic violence
 - 1. Defines coercion, controlling behavior and all types of domestic violence (e.g., psychological, emotional, sexual, physical, animal abuse, property, financial,

- isolation)
- 2. Identifies in detail the specific types of domestic violence engaged in, and the destructive impact of that behavior on the offender's partner and children
- 3. Demonstrates cognitive understanding of the types of domestic violence as evidenced by giving examples and accurately label situations
- 4. Defines continuum of behavior from healthy to abusive.
- I. Offender understanding, identification, and management of one's personal pattern of violence
 - 1. Acknowledges past/present violent/controlling/abusive behavior
- J. Offender understanding and use of appropriate communication skills
 - 1. Demonstrating non-abusive communication skills that include how to respond respectfully to the offender's partner's grievances and how to initiate and treat one's partner as an equal
 - 2. Demonstrates an understanding of the difference between assertive, passive, passive aggressive, and aggressive communication, and makes appropriate choices in expressing emotions
- K. Offender eliminates all forms of violence and abuse
- L. Offender identification and challenge of cognitive distortions that play a role in the offender's violence
 - 1. Offender demonstrates an understanding of distorted view of self, others, and relationships (e.g., Gender role stereotyping, misattribution of power and responsibility, sexual entitlement)

5.8 VI. Offender Additional Competencies

- A. Offender understands and demonstration of responsible parenting
 - 1. Demonstrates an understanding that abuse during pregnancy may present a higher risk to the victim and unborn child. The offender demonstrates sensitivity to the victim's needs (physical, emotional, psychological, medial, financial, sexual, social) during pregnancy.

III. Guidelines

A. Victim Considerations/Safety

Providers, Victim Advocates and others on MTT should have knowledge about the following:

- 1. Short and Long Term Impact
 - a. Guilt, fear, shame, depression, hyper vigilance, anxiety
 - b. Unhealthy coping skills
 - c. Decreased sense of self
 - d. Lack of recognition of what has happened to them
 - e. Struggles with trust
 - f. Safety planning
 - g. PTSD
 - h. Expense for victims of including counseling services and medical costs
 - i. Unintended consequences of reporting
- 2. Role of Victim Advocate
 - a. It is **not** the role of the advocate to inquire about or investigate sexual abuse or experiences of the victim

- b. To understand that victims are not being asked to report or discuss sexual abuse, but we do want to advise victims there are resources IF the victims wants to discuss these issues
 - c. Advocates should be prepared to handle spontaneous disclosures and seek training or support around this as needed
 - d. Safety planning
 - e. To communicate the curriculum utilized for offenders
 - f. To communicate offender's level of integration of treatment concepts and behaviors (where appropriate)
3. Competencies for Advocates
- a. Information about normalizing the range of response to sexual abuse
 - b. Help understanding what has happened to them: Some victims might not perceive they have experienced sexual abuse (societal beliefs, expectations in relationships)
 - c. Knowledge about coping mechanisms for victims
 - d. Symptoms of trauma and PTSD
 - e. Knowledge of predictors for sexual abuse in an intimate relationship (Reference item B.2)
 - f. Resources for victims
 - i. Know your local resources and what's available to people in your community.
 - ii. CCASA: 303-839-9999, <http://ccasa.org>
 - iii. National Sexual Assault Hotline: 1-800-656-HOPE (4673)
 - iv. RAIN : Rape Abuse and Incest National Network, online hotline, www.rainn.org
4. Resources for advocate information only: scales from victim perspectives:
- a. Partner Directed Insults (PDIS)¹
 - b. Sexual Coercion in Intimate Relationships (SCIRS)²

B. Provider Competency

In order to provide effective interventions in this area, providers are encouraged to pursue specialized training in the following areas:

Please also refer to Section H. Resources and J. Bibliography

- 1. Knowledge about healthy sexual behavior
- 2. Knowledge about predictors for sexual abuse in an intimate relationship
 - a. "Perceived" female infidelity,
 - b. Male low self-esteem,
 - c. Male alcohol and pornography consumption
 - d. Male sexual jealousy,
 - e. Men's partner directed insults,³
 - f. Men's controlling behavior toward their partner

¹ Items a-e: Starratt, V.G., et al. "Men's partner-directed insults and sexual coercion in intimate relationship." *Journal of Family Violence* 23.5 (2008): pg 315-323

² Goetz, A.T., Shackelford, T.K., "Sexual Coercion in Intimate Relationships Scale (SCIRS)", *Handbook of Sexuality-Related Measures*, (2010) pg 125-127

³ Items a-e: Starratt, V.G., et al. "Men's partner-directed insults and sexual coercion in intimate relationship." *Journal of Family Violence* 23.5 (2008): pg 315-323

- g. Men's physical and psychological partner directed aggression⁴
3. Knowledge regarding intimate partner sexual violence
4. Knowledge about subtle sexual coercion
5. Impact of sexual abuse on victims
6. Provider comfort level with discussing sexual issues

Discussion Item: While research demonstrates that most perpetrators are male, there are female perpetrators. Although research is limited on female perpetrators, some exhibit unhealthy sexual behaviors and attitudes toward their partners/victims.

C. Assessment Considerations

The goal is not to assess whether a client is a sex offender per statute nor is it to do a sex offense specific evaluation. However, it is important for treatment providers to begin exploring the following at evaluation and throughout treatment. Providers should begin to explore these issues with clients to normalize discussions on these topics.

1. Effective questions for exploring intimate partner sexual violence
2. Effective questions for exploring healthy sexual behaviors
3. Familiarity with intimate partner sexual violence scales such as:
 - a. Partner Directed Insults⁵
 - b. Sexual Coercion in Intimate Relationships (SCIRS)⁶
 - c. National Intimate Partner and Sexual Violence Survey (NISVS) 2010⁷
 - d. Sexual Coercion Questionnaire⁸
(Victimization Questions will have to be adjusted for use in working with the offender)

D. Evaluation

1. DV Providers are not intended, expected, nor necessarily qualified to perform a sex offense specific evaluation.⁹
2. DV Providers are not expected to do a separate assessment or evaluation on these issues, but to incorporate these areas into the normal evaluation and treatment.
3. Suggestions regarding assessment indicators are identified in Section B "Provider Competency" of this document.

⁴ Items f-g: Goetz, A.T., Shackelford, T.K. "Sexual Coercion in Intimate Relationships: A Comparative Analysis of the Effects of Women's Infidelity and Men's dominance and Control." *Archives of Sexual Behavior* 38.2 (2009): pg 226-234

⁵ Items a-e: Starratt, V.G., et al. "Men's partner-directed insults and sexual coercion in intimate relationship." *Journal of Family Violence* 23.5 (2008): pg 315-323

⁶ Goetz, A.T., Shackelford, T.K., "Sexual Coercion in Intimate Relationships Scale (SCIRS)", *Handbook of Sexuality-Related Measures*, (2010) pg 125-127

⁷ NISVS, "National Intimate Partner and Sexual Violence Survey, 2010 Summary Report" National Center for Injury Prevention and Control, Division of Violence Prevention

⁸ Kim, J.H. "Sexual Coercion Across Cultures: An Examination of Prevalence, Perceptions, and Consequences of Sexual Coercion in Korea and the United States." (2012)

⁹ Colorado Domestic Violence Offender Management Board, *Standards for Treatment of Court Ordered Domestic Violence Offenders*, (2010) Section 11.11 Offenses Involving Unlawful Sexual Behavior, pg 11-2.

E. Treatment Parameters and Dynamics

In order to provide effective interventions in this area, providers are encouraged to incorporate sexual abuse and healthy sexual behaviors in treatment content.

1. Incorporate into offender competencies such as those identified in Section II of this document
2. Discussion of sexual topics on a regular basis to normalize client/group comfort level with these issues
3. Referrals: When there is a conviction for an offense for which the underlying factual basis has been found by the court on the record to include an act of domestic violence, and the conviction includes a sex offense... that offender shall be evaluated and treated according to the *Colorado Sex Offender Management Board Standards and Guidelines For The Assessment, Evaluation, Treatment And Behavioral Monitoring Of Adult Sex Offenders*. (Standard 11.11) This would include consultation with probation and the SOMB provider.

F. Curriculum Resources

Providers are encouraged to address healthy sexual behaviors in treatment as well as addressing the differences between consent, cooperation, compliance and coercion.

The following are suggested resources (more information in bibliography):

1. Curriculums:
 - a. "Intimate Partner Sexual Abuse: A Curriculum for Batterer Intervention Program Facilitators" Commonwealth of Massachusetts¹⁰
 - b. Module I: Defining Intimate Partner Sexual Abuse and Assessing Its Prevalence, National Judicial Education Program, also listed here under H. Resources: (www.njep-ipsacourse.org)
 - c. Steve Brown's Older, Wiser, Sexually Smarter, and Street Wise to Sex Wise
 - d. Berman, Laura, *Loving Sex: The book of joy and passion*
 - e. Leman, Kevin. *Sheet music: Uncovering the secrets of sexual intimacy in marriage*

G. Supervision/Consultation Considerations

- a. Consultation with SOMB providers as needed on specific cases
- b. General consultation with SOMB providers; consultation could benefit both professions due to high crossover of these behaviors
- c. Outreach to rape crisis staff, victim services such as Colorado Coalition Against Domestic Violence, Colorado Coalition Against Sexual Assault and local community based programs
- d. Supervision regarding group dynamics or special cases with DV Clinical Supervisor or Peer Group

H. Resources

1. Trainings and Information
 - a. SOMB website: <http://dcj.state.co.us/odvsom>
 - b. DVOMB website: <http://dcj.state.co.us/odvsom>
 - c. CCASA website: <http://ccasa.org>
 - d. CCADV website: <http://ccadv.org/>
 - e. National Judicial Education Program web course: Intimate Partner Sexual Abuse:

¹⁰Rothman, EF, Allen, C, & Raimer, J. (2003). "Intimate Partner Sexual Abuse: A Curriculum for Batterer Intervention Program Facilitators". *Commonwealth of Massachusetts, Executive Office of Public Safety*: Boston, MA. <http://www.mass.gov/eohhs/docs/dph/com-health/violence/bi-curriculum.pdf>

- Adjudicating this Hidden Dimension of Domestic Violence Cases. Module One, Two and Three. www.njep-ipsacourse.org
- f. CDC website: <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html>
- g. National Institute of Health: multiple articles and research findings: nih.gov

I. Definitions

Abusive Sexual Contact

- Intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse. http://www.cdc.gov/violenceprevention/pdf/SV_Surveillance_Definitionsl-2009-a.pdf

Assumption

- Thinking you know something when you haven't checked it out. <http://www.yesmeansyes.com/DEFINITIONS>

Coercion

- Coercion is the use of emotional manipulation to persuade someone to something they may not want to do - like being sexual or performing certain sexual acts. Examples of some coercive statements include: "If you love me you would have sex with me.", "If you don't have sex with me I will find someone who will.", and "I'm not sure I can be with someone who doesn't want to have sex with me."...Being coerced into having sex or performing sexual acts is not consenting to having sex and is considered rape/sexual assault. <http://www.clarku.edu/offices/dos/survivorguide/definition.cfm>
- **Bribes, lies, threats, guilt:** Methods of manipulation and coercion used to force or trick someone to be sexual. May be used to force someone to consent, to say yes, to sexual acts they don't really want to do. <http://www.yesmeansyes.com/DEFINITIONS>
- **Emotional Pressure:** Taking advantage of the level of trust or intimacy in a relationship. Exploiting the emotions or threatening to end the relationship. Making you feel guilty about not engaging in sexual activity and wearing him/her down by using the same tactic over and over again. Phrases like these may be used: "If I don't get it from you, I will get it from someone else." "I want to show you how much I care about you." "If you love me, you will have sex with me." "You have had sex before, what's the problem?" <http://www.afspc.af.mil/news/story.asp?id=123222934>
- **Verbal Pressure:** Begging, flattery, name calling, tricking, arguing, lying or misleading. <http://www.afspc.af.mil/news/story.asp?id=123222934>

Consent

- **Colorado Revised Statutes:** Consent means cooperation in act or attitude pursuant to an exercise of free will and with knowledge of the nature of the act. A current or previous relationship shall not be sufficient to constitute consent. Submission under the influence of fear shall not constitute consent. Source: 18-3-401(1.5) (1992).
- A mutual, verbal, physical, and emotional agreement that happens without manipulation, or threats. <http://www.yesmeansyes.com/DEFINITIONS>

- Is clear permission between intimate partners that what they are doing is okay and safe. To consent to something - like being sexual - means both parties confidently agree to do it based on their own free will without any influence or pressure. A person cannot legally consent if they are drinking or under the influence of drugs as their ability to consent has been impaired. <http://www.clarku.edu/offices/dos/survivorguide/definition.cfm>
- **Inability to Consent** - A freely given agreement to have sexual intercourse or sexual contact could not occur because of age, illness, disability, being asleep, or the influence of alcohol or other drugs. http://www.cdc.gov/violenceprevention/pdf/SV_Surveillance_Definitionsl-2009-a.pdf

Cooperation

- A victim may cooperate in order to protect one's self based on fear, or an effort to prevent bodily harm and/or fear of death, this is not consent.
- A victim's cooperation may look like consent, but it's not if they are cooperating to protect themselves.

Intimate Partner

- **Colorado Revised Statutes:** Intimate relationship means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time. Source: 18-6-800.3(2) (1994).

Non-physical sexual coercion

- The imposition of sexual activity on someone through the threat of nonphysical punishment, promise of reward or verbal pressure rather than through force or threat of force. Sexual activity forced upon a person by the exertion of psychological pressure by another person. <http://quizlet.com/dictionary/sexual-coercion/> These tactics can include the use of lies, guilt, false promises, continual arguments, and threats to end the relationship, or ignoring verbal requests by the victims to stop (without using force). [Understanding Perpetrators of Nonphysical Sexual Coercion: Characteristics of Those Who Cross the Line](#)

Sexism

- Sexism is the system of attitudes, assumptions, actions and institutions that treat {one gender} as inferior and make {that gender} vulnerable to violence, disrespect and discrimination. Sexism is intensified and compounded by other systematic imbalances of power because of class, race, age, sexual orientation and physical/mental ability. In our country, its generally women that are seen as inferior and are in general more susceptible to violence. <http://www.clarku.edu/offices/dos/survivorguide/definition.cfm>

Sexual Abuse

- Coercing or attempting to coerce any sexual contact or behavior without consent. Sexual abuse includes, but is certainly not limited to: marital rape, attacks on sexual parts of the body, forcing sex after physical violence has occurred, or treating one in a sexually demeaning manner. [Office on Violence Against Women, US Department of Justice](#)

- Sexual abuse is any sort of non-consensual sexual contact. Sexual abuse can happen to men or women of any age. Sexual abuse by an intimate partner can include: derogatory name calling, refusal to use contraception, deliberately causing unwanted physical pain during sex, deliberately passing on sexual disease or infections and using objects, toys, or other items (e.g. baby oil or lubricants) without consent and to cause pain or humiliation. <http://www.pandys.org/whatissexualabuse.html>

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Educational

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Other Reading

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Appendix I: DVOMB Position Paper Regarding Interactive Electronic Therapy

I. Board Position

The DVOMB has determined that interactive electronic, online, remote or e-therapy is not appropriate for domestic violence offender treatment for the criminal justice population and is therefore prohibited.

II. Definitions

A. Interactive Electronic Therapy (E-Therapy)

E-therapy is the use of electronic media and information technologies to provide services to participants in different locations¹

A. Domestic Violence Offender Treatment

Domestic violence treatment is the assessment, evaluation, group or individual therapeutic contacts, and second clinical contacts, related to the offender's treatment plan as per *Standards 4.0*.

A. Face to Face Contact

The current Standards do not define face to face contact. Therefore the Board now defines face to face contact as **the Approved Provider and the offender are both in person, in the same room, at the same time.**

Therefore, domestic violence treatment **must be conducted face to face and requires that the Approved Provider and the offender are both in person, in the same room, at the same time.**

III. Additional References in the Standards

The following sections of the Standards reference face to face contact:

- Definitions section, Appendix C, "Face-to-Face Client Contact Hours."
- 5.06 Levels of Treatment, (VIII.) Level C (High Intensity), (B) (1.) (c), "Face to face contact is required so the Approved Provider can assess the offender's attention level responsiveness, appearance, possible substance abuse, and mental health status. This contact will also assess and promote victim safety."
- 5.01 Basic Principles of Treatment - "Provision of Treatment: Treatment, evaluation, and assessment shall be provided by an Approved Provider at all times."

IV. Discussion of Prohibition of E-Therapy

Domestic violence offender accountability is key at all levels of mandatory, offender treatment. Being physically present with an offender becomes critical for ongoing assessment and holding an offender accountable. Additionally, the development of a therapeutic relationship is critical to promoting change in treatment, and face to face contact helps encourage this aspect of treatment.

This policy does not prevent an Approved Provider from managing a crisis by phone with an offender where appropriate. For example, an Approved Provider may determine it is appropriate to manage

¹ Definition obtained from: (SAMHSA *Considerations for the Provision of E-Therapy* <http://store.samhsa.gov/shin/content/SMA09-4450/SMA09-4450.pdf>)

a crisis by responding to a phone call from an offender, or initiating a phone call with an offender.

This policy also would not prevent an adjunct educational component recommended by the MTT (not a second clinical contact) that the offender accesses online, such as how to build a resume.

The prohibition of e-therapy does not prevent an Approved Provider from having a phone conversation with an offender or emailing an offender about practical matters such as setting appointments, addressing billing issues or managing paperwork, as long as it does not constitute treatment.

Appendix J: Working with DV Offenders Involved In the Military Adopted (August 12, 2016)

The following Guidelines have been developed to address the unique aspects of treatment with domestic violence offenders who also have military experience. These Guidelines supplement the DVOMB *Standards and Guidelines* and are found in the Appendix of the Standards.

The treatment issues unique to military require that providers working with this population have specific experience, knowledge, and assessment skills to effectively assess for and provide treatment. It is imperative that treatment providers are prepared to assess and respond to the myriad of experiences and needs within military offender populations. Providers must seek appropriate training to work effectively with this population. Providers are encouraged to use these guidelines and seek to increase their competence in working with diverse groups of offenders who have had military experience.

A. Recommended Competencies for Providers

1. PTSD - Post Traumatic Stress Disorder (PTSD) current research indicates that PTSD is not a causal factor in domestic violence. Research further demonstrates that combat exposed veterans are more likely to exhibit symptoms of combat operational stress (combat operational stress reactions COS-R) than an actual full blown PTSD diagnosis. Clinicians should understand the diagnostic criteria for PTSD as well as be versed in combat operational stress.
2. TBI - Traumatic Brain Injury is a significant neurological injury and should be evaluated and treated by a neurologist. Providers should obtain a release of information and consult with the treating neurologist. The key issues to explore would be the offender's ability to participate meaningfully in the treatment process, the offender's ability to retain new information and the offender's ability to emotionally self-regulate.
3. Deployment cycle, also known as the Army Force Generation (ARFORGEN) cycle, is the military's training and deployment cycles. It affects both the Service Member and the family as Service Members are typically either deploying or preparing to deploy. What stage a Service Member is in may affect their ability to participate in weekly treatment as well as potentially create significant stress factors for the military family.
4. Military culture and customs - The military has a unique culture which is steeped in history, values and traditions. The DVOMB considers understanding the military and its unique culture a cultural competency issue for practitioners.
5. Uniform Code of Military Justice (UCMJ) is the legal code which governs Service Members and their behaviors. Even if a Service Member is sentenced in a civilian court of law, their actions can still be adjudicated under UCMJ. Understanding judicial and administrative actions can assist a provider in understanding a Service Member and also potentially assist in managing risk. Providers treating military personnel should know the offender's First Sergeant (1SG) and Company Commander, have a release of information for both and coordinate care with one or both throughout treatment.

The offender should provide the treatment provider with the Command and 1SG's contact information. NOTE: You will need a release of information to speak with either the Commander or a 1SG as confidentiality limits apply.

6. Protective orders can be civil (temporary protection order -TPO, or permanent protection order - PPO, or military protection order - MPO). A MPO is issued by the Commander and is typically time limited. Unless the Commander specifically processes the MPO through the Military Police, the MPO is ONLY valid ON POST. This is important to note as a MPO will not protect a victim off post UNLESS the Commander has had the MPs put the MPO into NCIC. It is extremely rare for a Commander to do this as the MPOs are time limited, typically 1 week to 1 month.
7. Service Members with a MPO can and do still have access to weapons. In order to restrict access to weapons, the Service Member must voluntarily surrender them OR an on post Behavioral Health Provider must write a weapons profile. Conversely, if a Service Member has a PPO, they are prohibited from owning and possessing personally weapons. However, they may still use a weapon as part of their military duty (i.e. they can still deploy and be issued a government weapon).

B. Assessment Considerations

1. Deployments - the number and frequency of deployments is a significant assessment consideration. Ideally, a Service Member is granted one year stabilization between deployments. However, if a Service Member returns from deployment and moves to a new unit, that unit may be preparing to deploy and thus the Service Member and the military family would have repeated back to back deployments. Assessment considerations would include, stress, separation and reunification issues, parenting issues and finances.
2. Combat exposure - not all deployments involve combat exposure. Many deployments result in what Service Members refer to as being a "Fobette" meaning they stayed on the FOB (Forward Operating Base) the entire deployment. Assessment considerations in this scenario would include boredom, morale and separation issues as well as meaningfulness of service issues.
3. Disability issues - a Service Member may have a service related disability. Again, research has failed to establish a causal factor between combat and domestic violence. However, serving on active duty with a disability creates significant stress for the Service Member and the unit. Additionally, the process for obtaining a medical discharge is lengthy and frustrating for the Service Member and the military family. Assessment considerations would include financial concerns, loss of purpose, fear of the unknown, unit support or lack thereof, guilt, etc.
4. Collateral loss (loss of battle buddies/fellow Service Members) is a significant issue for Service Members. Assessment considerations would include survivor's guilt, COS-R and/or PTSD symptoms.
5. Insomnia - a significant number of Service Members report significant and long term sleep disruptions. On post behavioral health offers many sleep specific programs to help Service Members with their sleep issues. Conversely, as clinicians, we know that

long term sleep deprivation is a significant clinical issue which requires intervention for any therapeutic program to be effective.

6. Substance abuse - Service Members who struggle with substance abuse can seek confidential substance abuse treatment via Army Substance Abuse Program (ASAP). If the Service Members waits until their substance abuse issues become known to Command, their career could be negatively affected. Clinicians may want to encourage Service Members to seek voluntary, confidential help if they suspect any substance abuse issues are present. Once Command becomes aware of any use/misuse issues, they will Command direct the Service Member to complete an evaluation. Confidentiality for the Soldier is EXTREMELY limited in these cases, so it may be best that a Service Member self refers for a substance use/abuse treatment or education. Currently, Service Members who are identified as having substance abuse issues could face separation from the military.

C. Treatment Parameters and Dynamics

1. Understanding the functional power structure of defense - Providers treating military personnel should consider the efficacy of the power and control structure that is embedded within the military culture.
2. Providers should consider the unique way in which military personnel define “threat” and seek to assist Service Members in exploring the ways in which the military requires/trains them to respond to threats versus how a family would need them to define and respond to a perceived threat.
3. The military, by virtue of the ARFROGEN cycle, significantly disrupts family attachment, roles and routines. Continued deployment and redeployment can create significant disruption to familial roles, expectations and family processes. This can and often does create significant conflict. Assessment considerations would include family roles and rules, attachment patterns, expectations regarding parenting and child development. Additionally, due to how rapidly children develop and grow, Service Members often have to grieve the loss of the child(ren) they knew when they left versus the child(ren) that greets them upon redeployment. Spouses, similarly, may change and grow over the course of repeated deployments, which can create significant disruptions to the military family.

D. Supervision/consultation issues

1. The provider working with military families should assure that they have adequate training and support for themselves and for their victim advocate.
2. The Provider should have a working relationship with the closest military base’s Department of Behavioral Health (DBH), Family Advocacy Program at DBH and Family Advocacy Program via Army Community Services (ACS). If the Service Member has been discharged, the provider should have resources and connections with the local VA Hospital and outpatient clinic.

E. Victim advocacy

1. Similar to the treatment provider, a treatment victim advocate working with military victims should know and understand PTSD, TBI and COS-R. Moreover, they should seek to help victims understand that PTSD is not an excuse for domestic violence.
2. Treatment victim advocates should be connected to the unique benefits available to military victims to include medical care, MPOs and transitional compensation.
3. A treatment victim advocate must be able to help victims discuss the pros and cons of a civilian versus a military protection order and the implications for both.
4. A treatment victim advocate working with military victims should understand the unique implications (i.e. UCMJ actions) which can and often do affect pay, restrictions to post and ultimately discharge from active duty. These are serious concerns for military victims which ideally should be explored and discussed so that the victim can make an informed decision for themselves and their families. The treatment victim advocate will need a release of information to speak with a military victim advocate. The treatment victim advocate should discuss what the military victim advocate would have to report to the MEDCOM Family Advocacy Program prior to sharing any information. A military victim advocate does not serve in the role as a treatment victim advocate.
5. Military victims have a right to “restricted” versus “unrestricted reporting” and military victim advocate should be well versed in these two reporting options. It may behoove a military victim to file a restricted report with a military victim advocate as later, should they need it, they can unrestrict the report and document that they did share concerns with ACS.

Resources

http://www.dtic.mil/doctrine/dod_dictionary/

<http://www.defense.gov/About-DoD/insignias>

Appendix K: Guidelines for Young Adult Offenders Adopted February 10, 2017

I. Introduction

The purpose of this appendix is to provide Multi-Disciplinary Treatment Teams (MTTs) with additional guidance on working with domestic violence offenders ages 18-25, who can be classified as young adults (note, this population is also sometimes referred to as transitioned-aged). This informational document provides MTTs with best practices guidelines, potential risk and protective factors, and suggestions for the treatment and case management of young adults. The guidelines in this appendix do not replace any of the mandates currently required in the *Standards*. A Young Adult Committee of the DVOMB was convened to develop these Guidelines. The Committee, comprised of state and local experts in the field of at-risk youth, delinquent juveniles, and young adult populations (including treatment providers, victim service providers and advocates, probation/corrections officers, and others involved in the criminal justice system) collaborated on the creation of this Appendix. Clinical and professional expertise, as well as a review of available research and literature, served as the foundation for these Guidelines.

The Risk, Need, and Responsivity (RNR) principles are an evidence-based framework for evaluating, treating and supervising individuals involved with the criminal justice system. The RNR principles originated from numerous high-quality and generalizable studies in the broader criminological literature (Andrews & Bonta, 2010). The RNR principles state the following:

- Risk - Services provided to offenders should be proportionate to the offenders' relative level of static and dynamic risk (i.e., low, moderate, or high risk) based upon accurate and valid research-supported risk assessment instruments;
- Need - Interventions are most effective if services target criminogenic needs (both social and psychological factors) that have been empirically associated with recidivism; and
- Responsivity - Effective service delivery of treatment and supervision requires individualization that matches the offender's strengths, culture, learning style, and abilities, among other factors. (Please see Appendix E (VI) - Responsivity Principle and Factors).

The DVOMB recognizes that based on responsivity issues and the needs of young adults, a different approach may be needed when addressing the unique challenges of this population. Neurobiological research gives us a deeper understanding of adolescent, young adult brain development, and neuro-psychology.¹ This research indicates that the brains of young adults are more fluid, and are still developing and changing until the age of 25 (Perry, 2009; Spear, 2010, Teicher, 2002). As a result, some young adults may not recognize the consequences of their behaviors and may present more like an adolescent rather than an adult. Research indicates that over-responding to non-criminal violations with this population can cause more harm than good for the offender, victim and community (Teicher, 2002). As a result, young adults are at higher risk for dropping out of treatment (Buttell & Carney, 2008; Jewell & Wormith, 2010), therefore, it is imperative for MTT members to

¹ During adolescence, the human brain experiences increased growth, connectivity, and synaptic pruning (Spear, 2010). The rate at which the development of the neural pathways associated with regulation and reward sensitivity may provide insight into the characteristics of emerging adulthood.

assess and treat this population within a framework that is appropriate for this population.

Disclaimer of Risk and Safety Issues: The information outlined in this Appendix does not replace, change or supersede the risk factors identified by the Domestic Violence Risk and Needs Assessment (DVRNA) as part of the Offender Evaluation. These guidelines offer recommendations to lower risk and enhance responsivity by increasing treatment readiness and amenability to make positive behavioral change. Additional offender competencies are necessary to address specific issues unique to the development of the young adult population that may not be currently addressed by Standard 5.08. Appropriate interventions should be commensurate with the nature and severity of the behavior and the degree to which it relates to risk. Risk of harm to others must not be ignored and should be balanced when assessing impulsive behavior typical in adolescence versus more criminal and anti-social characteristics, which are indicative of heightened risk.

II. Guiding Principles

The Guiding Principles (described in Section 3.0) are designed to assist and guide the work of those involved in the management and containment of domestic violence offenders. For the purposes of this Appendix, the following guiding principles in the Standards may or may not be relevant or appropriate for young adult offenders.

Guiding Principle	Issue for Consideration with Young Adults
<p>GP 3.06 - It is the nature of domestic violence offenders that their behaviors tend to be covert, deceptive, and secretive. These behaviors are often present long before they are recognized publicly.</p>	<p>Young adults may not have a prior history of domestic violence due to their age, and a history of delinquency may be more prevalent. Impulsivity and poor decision-making may be attributed to the index offense. As a result, deceptiveness and secrecy may not be as normative with young adults.</p>
<p>GP 3.13 - The preferred treatment modality is group therapy.</p>	<p>Research and clinical experience indicates that young adults tend to respond better to a combination of both individual and group sessions. If not, negative therapeutic outcomes may occur by exposing young adults to older adults who are higher risk and developmentally more mature (Abracen et al., 2016; Lowencamp & Latessa, 2004).</p>
<p>GP 3.15 - Offender treatment must address the full spectrum of abusive and controlling behaviors associated with domestic violence, and not just the legally defined criminal behavior(s).</p>	<p>Young adults may be at a developmental stage where maladaptive patterns of violence (with intimate partners and significant others) may not fully be present, but may or may not require an intervention that addresses the full-spectrum of abusive and controlling behaviors.</p>

III. Young Adult Risk and Protective Factor Considerations

Given the emerging research on young adults, it is important for the MTT to evaluate an offender's problematic behavior and assess their developmental maturation. When responding to rule breaking or non-compliance, it is best to determine whether or not it signifies an increase in risk. If so, the MTT should assess what needs exist and what intervention best addresses those needs and manages risks appropriately. Such assessment should include strengths and protective factors.²

Contributing risk factors in young adults will likely be best mitigated by ensuring the MTT prioritizes the RNR principles and ensures all of these are assessed and addressed in treatment. The DVRNA is based on adult risk factors and does not address protective factors that may be present within young adult clients. Providers should consider research-supported developmentally-appropriate risk and protective factors in the ongoing assessment and case management of young adults (see attachment 1 for examples of potential risk and protective factors for this population). Providers should exercise clinical judgement with these cases in terms of identification of risk and protective factors, and consult with other professionals as needed.

Risk Assessment Instruments and Collateral Information

The DVRNA instrument still applies to the young adult population. However, young adults may possess issues that require further assessment and consideration of risk and needs. Adult risk assessment instruments may or may not necessarily address the unique factors of the young adult population. After conducting a thorough evaluation, in accordance with Section 4.0 of the Standards, alternative risk assessments may be appropriate in some cases to use for juveniles under the age of 18 for informational purposes only. It is important to note that using a juvenile risk assessment instrument on an individual over the age of 18 is not a validated assessment of risk, but may be informative for case planning.

IV. Responsivity Issues Affecting Young Adults to Consider

The MTT should individualize treatment and supervision for young adults, to the extent possible, in relation to their present development, deficits and amenability to treatment. Group-specific sessions for young adults should be considered and utilized by providers (where applicable), in order to minimize the exposure of young adults to older adults who are higher risk and developmentally more mature. Additionally, it may be more appropriate for young adults to receive individual sessions instead of group sessions based on the clinical judgement of a provider. Providers utilizing individual sessions with young adults should develop treatment plans that address the client's individual needs, their Core Competencies and other unique issues present.

It is important for the MTT to also understand the characteristics of offenders that may be more likely to lead to treatment dropout. The research indicates that a client is more likely to complete treatment if they are older and employed (Buttell & Carney, 2008; Jewell & Wormith, 2010). As a result, the challenges associated with emerging adulthood such as finding stable housing, employment and relationships may increase treatment dropout for young adults. Providers should consider any healthy and pro-social factors that may assist a young adult client's initial engagement

²Protective factors are conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk in families and communities.

in the therapeutic process and commitment over time, and focus on development of protective factors.

V. MTT Guidelines for Decision-Making

MTTs are encouraged to assess and develop individualized treatment plans including containment efforts for young adults, based on their maturation and risk levels. Independent living skills, risk, and protective factors should be discussed by MTTs and factored into programming for the offender. MTTs should consult with other experienced adult and juvenile practitioners to assist in the development of effective treatment and supervision, and to identify possible resources that may aid in information gathering, where such experience is lacking.

Recommendations:

- Use an evidence-based, research-informed or best practice curriculum for this population (see for example, Gibbes, L. & Myers, L., 2011)
- Consider the following treatment issues, among others:
 - Self-efficacy and self-identity
 - Empathy
 - Developmental stage
 - Appropriate boundaries and communication in relationship
 - Age appropriate healthy sexuality
 - Age appropriate healthy sexual behavior
 - Appropriate use of electronic devices and social media
 - Appropriate dating skills
 - Positive support groups and peer associations
- Consider additional core competencies, as appropriate (See Section 5.08, VI)
- Support ongoing research to better inform interventions with this population
- Stay current on research related to this population, including developmental issues
- Consult with other professionals as needed
- Participate in trainings on:
 - Human development and maturation of young adults
 - Brain development and neuro-psychology

VI. Links to Resource Documents

Gibbes, L. & Myers, L. (2011). Colorado Teen Dating Violence Prevention Final Report Primary Prevention of Teen Dating Violence in the Denver-Aurora Community: Best Practices and Strategy Recommendations. Colorado Department of Public Health and Environment.

[Click Here](#)

Oudekerk, B., Blachman-Demner, D., & Mulford, C. (2014). Teen Dating Violence: How Peers Can Affect Risk & Protective Factors. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, NCJ 248337.

[Click Here](#)

Attachment 1 - Examples of Potential Risk and Protective Factors for this Population

This table is meant to be a resource that lists some possible risk and protective factors associated with youth that may be considered for young adults. This is not exhaustive list of risk or protective factors as there may be others that should be considered by the MTT. Providers should consider research-supported developmentally-appropriate risk and protective factors in the ongoing assessment and case management of young adults. Providers should exercise clinical judgement with these cases in terms of identification of risk and protective factors, and consult with other professionals as needed.

Table of Risk and Protective Factor Chart

Domains	Risk Factors	Adolescent Problem Behaviors						Protective Factors
	Risk factors increase the likelihood youth will develop problem behaviors	Substance Use	Depression/ Anxiety	Delinquency	Teen Pregnancy	School Dropout	Violence	Protective factors help protect or buffer the risks of youth developing problem behaviors.
Community	Availability of alcohol/ other drugs	x					x	1. Opportunities for prosocial involvement in the community 2. Recognition of prosocial involvement
	Availability of firearms			x			x	
	Community laws and norms are favorable toward drug use, firearms and crime	x	x	x			x	
	Transitions and mobility	x		x				
	Low neighborhood attachment and community disorganization	x		x			x	
	Media portrayals of violence	x		x			x	
	Extreme economic deprivation	x		x	x	x	x	
Family	Family history of problem behavior	x	x	x	x	x	x	1. Bonding to family with healthy beliefs and clear standards 2. Attachment to family with healthy beliefs and clear standards 3. Opportunities for prosocial involvement 4. Recognition for prosocial involvement
	Family management problems	x	x	x	x	x	x	
	Family management problems	x	x	x	x	x	x	
	Family conflict	x		x	x	x	x	
	Favorable parental attitudes	x		x			x	

Table of Risk and Protective Factor Chart, continued...

Domains	Risk Factors	Adolescent Problem Behaviors						Protective Factors
	Risk factors increase the likelihood youth will develop problem behaviors	Substance Use	Depression/ Anxiety	Delinquency	Teen Pregnancy	School Dropout	Violence	Protective factors help protect or buffer the risks of youth developing problem behaviors.
School	Academic failure beginning in late elementary school	x		x	x	x	x	<ol style="list-style-type: none"> 1. Bonding and attachment to school 2. Opportunities for prosocial involvement 3. Recognition for prosocial involvement
	Lack of commitment to school	x		x	x	x	x	
Individual/Peer	Early and persistent antisocial behavior	x		x	x	x	x	<ol style="list-style-type: none"> 1. Bonding to peers with healthy beliefs and clear standards 2. Attachment to peers with healthy beliefs and clear standards 3. Opportunities for prosocial involvement 4. Increase in social skills
	Rebelliousness	x	x	x		x		
	Friends who engage in the problem behavior	x		x	x	x	x	
	Favorable attitudes toward the problem behavior	x		x	x	x		
	Early initiation of the problem behavior	x		x	x	x	x	
	Gang involvement	x		x			x	
	Constitutional factors	x	x	x			x	

Source: Hawkins, J., Catalano, R., Arthur, M. (2002). Promoting science-based prevention in communities. *Addictive Behavior*, 27(6):951-76.

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