Colorado Domestic Violence
Offender Management Board

STANDARDS FOR TREATMENT WITH COURT ORDERED DOMESTIC VIOLENCE OFFENDERS

Colorado Department of Public Safety
Division of Criminal Justice
Office of Domestic Violence and Sex Offender Management

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Introduction

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 Section 16-11.8-103, C.R.S. The legislative declaration in the Board's enabling statute states that the consistent and comprehensive evaluation, 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.). The Board was charged with the promulgation of standards for the evaluation, treatment and monitoring of convicted domestic violence offenders and the establishment of an application and review process for approved providers who provide services to convicted domestic violence offenders in the state of Colorado.

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, treatment and 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.

1.0 Domestic Violence Offender Management Board Members

To contact the Board, request copies of these *Standards,* the Approved Provider List, a new application, or to receive DVOMB meeting notices, please contact the DVOMB Staff at:

Domestic Violence Offender Management Board
Division of Criminal Justice
Colorado Department of Public Safety
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Denver, CO 80215
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The Domestic Violence Offender Management Board consists of the following members, as of September 2010:

Timothy L. Johnson, Esq. (Chairperson)
Boulder District Attorney's Office
Representing Prosecuting Attorneys

Margaret Abrams, MA, (Vice Chairperson)
Denver District Attorney's Office
Representing Urban Coordination of Domestic Violence Victim Advocacy

Lt. Howard Black
Colorado Springs Police Department
Representing Law Enforcement

Robin Leaf
18th Judicial District Probation
Representing the Judicial Department/Office of Probation Services

Jenni Guentcheva, LPC, LAC
Rocky Mountain Behavioral Health
Representing Licensed Professional Counselors

The Honorable Jonathan Walker
El Paso County Combined Courts
Representing Judges

Cindi Rieb, MA
Representing the Colorado Department of Regulatory Agencies

Ruth M. Glenn, MPA
Representing the Colorado Department of Human Services

Jennifer Walker, MPA
Women's Crisis & Family Outreach
Representing Domestic Violence Victims and Victim's Organizations

Ed Marshall, Psy.D.
Representing Licensed Psychologists

Javier Del Castillo, LCSW, CAC III
Evans Army Community Hospital-SWS / Family Advocacy Program
Representing Licensed Social Workers

Amy Miller, MSW
Colorado Coalition Against Domestic Violence
Representing Domestic Violence Victims and Victim's Organizations

Chris Lobanov-Rostovsky, LCSW
Representing the Colorado Department of Public Safety/Division of Criminal Justice

Jackie Sievers
Hilltop/Child & Family Services
Representing Rural Coordination of Criminal Justice & Victims Services

Clyde Chambers, LMFT, CAC III
Aurora Mental Health: The Offenders' Group
Representing Licensed Marriage and Family Therapists

John Cogley, M.Div.
Cogley's Counseling Assn. & Counter Measures
Representing Unlicensed Mental Health Professionals

David M. Lipka, Esq.
Representing Office of the State Public Defender's Office

David Harrison, Esq.
Miller & Harrison, LLC
Representing Private Criminal Defense Attorneys

Sara Phelps
Representing the Department of Corrections

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 for Treatment with Court Ordered 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.

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. Court ordered 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* 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* 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*. 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*. 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 court ordered 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 Court ordered 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

4.01 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.

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

4.03 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.

4.04 Initial Pre-Sentence or Post-Sentence Intake Evaluation
"Evaluations" are conducted prior to sentencing or at the beginning of offender treatment, whereas "assessments" are specific components of the evaluation that are also used to measure progress and risk throughout treatment.

4.05 Priority of Treatment Evaluation
The initial priorities of the treatment evaluation are to identify the risk level and needs of the offender related to treatment, containment, and stabilization.

4.06 Parameters of the Evaluation
The criminal justice system, not the Approved Provider, is responsible for making legal decisions regarding guilt or innocence, pleas, convictions, and sentencing. When an Approved Provider performs an evaluation pre- or post-sentence, the presumption is that the offender is guilty and will complete domestic violence offender treatment per the *Standards*. 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 other than recommendations specified below in [I. Pre-Sentence Evaluation]. If a pre-plea evaluation has been performed, once there is a finding of guilt, an evaluation that complies with the Standards shall be utilized to determine treatment needs.

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

I. Pre-Sentence Evaluation
A pre-sentence evaluation shall only be conducted by an Approved Provider who is a licensed mental health professional, and who will also provide an assessment of mental health issues as indicated.

The pre-sentence evaluation is not a required evaluation for offenders. An Approved Provider may perform a pre-sentence evaluation to obtain information

that will allow the Approved Provider to make treatment recommendations related to strategies for offender containment, monitoring, and supervision requirements based on assessments of an offender's risk, needs, and responsivity. The pre-sentence evaluation shall comply fully with the *Standards.*

When the substance abuse screening and/or clinical judgment indicate the need for further assessment, the offender shall be referred to a Certified Addictions Counselor (CAC II, III) or Licensed Addictions Counselor (LAC) for a substance abuse assessment**.**

II. Post-Sentence Intake Evaluation
The post-sentence intake evaluation is a required component of the offender's intake process and shall be conducted on each offender by an Approved Provider. In cases in which a pre-sentence evaluation has been completed and a copy has been obtained by the Approved Provider, the post-sentence intake evaluation shall expand on the pre-sentence evaluation as necessary (Reference "Required Minimum Sources of Information" Section 4.08). 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.

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.

Once the post-sentence evaluation is completed, the Approved Provider shall obtain the consensus of the Multi-disciplinary Treatment Team (MTT) regarding the initial treatment plan. The MTT includes, at a minimum, the supervising criminal justice agency (e.g. probation officer), Approved Provider, and victim advocate (Reference *Standard* 5.02 for a definition of the MTT).

4.07 Pre- and Post-Sentence Evaluation Purposes:

I. Evaluation(s) 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.

II. Evaluation(s) shall be conducted to identify the following factors: risk of re-offense and/or further abuse, offender criminogenic needs, offender responsivity to treatment, and other treatment issues as identified in Section 4.08 "Required Minimum Sources of Information." These factors shall assist in determining recommendations regarding offender treatment.[1]

[1]James Bonta, "Offender Risk Assessment: Guidelines for Selection and Use," Criminal Justice and Behavior, 2002: 355-379.

III. Evaluation(s) shall be used to develop baseline measures in order to assess offender gain or deterioration with regard to criminogenic need and risk of reoffense.

IV. 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.

V. Evaluation(s) shall direct initial placement of the offender into the appropriate level and intensity of treatment as identified in *Standard* 5.06.

VI. Specific goals of the evaluations shall include the following:

- Determination of the level and nature of risk**,** including possible lethality for future domestic violence (Reference Appendix E Section VII)
- Identification of individual criminogenic factors/needs (Reference Appendix E Section IV)
- Identification of strategies for managing criminogenic factors/needs and potential destabilizing factors
- Identification of offender strengths (e.g., pro-social support, employment, education)
- Initial recommendations for treatment planning
- Initial recommendations for offender monitoring related to community and victim safety, if applicable
- Assessment of offender responsivity (Reference Appendix E Section VI)
- Assessment of offender accountability (Reference Appendix E Section I)
- Assessment of amenability for treatment is defined as:
  - The ability to comprehend treatment concepts
  - The physical and mental ability to function in a treatment setting
- Assessment of whether the offender is inappropriate for domestic violence offender treatment [Reference *Standard* 4.09 (IV)(E)].

4.08 Required Minimum Sources of Information:

To determine the most accurate prediction of risk, as well as offender treatment planning that comports with best practices, evaluations shall include external sources of information, which include 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. Required External Sources of Information[2]

[2] P. Randall Kropp, et al., Manual for the Spousal Assault Risk Assessment Guide, 2nd ed. (Vancouver, BC: The British Columbia Institute Against Family Violence, 1995) 13-14.

A. Criminal justice and/or court documents including but not limited to the following:
- Law enforcement reports that could include victim statements, other witness statements, and photos from current and prior incidents, if applicable
- Criminal history

B. Victim input, including but not limited to: victim impact statement if available, written reports, direct victim contact, and/or information via victim advocates, and/or victim therapists

Discussion Point: Women's perceptions of safety are substantial predictors of reassault[3]

C. Available collateral contacts directly related to the current offense (e.g., medical and mental health practitioners, departments of human services)

D. Other collateral contacts as relevant (e.g., former partners, family members)

E. Previously performed offender evaluations as relevant (e.g., psychological, psychiatric, substance abuse, or medical)

F. Efforts to obtain a copy of a pre-sentence evaluation if previously completed shall be pursued and the evaluation shall be reviewed in its entirety. The purpose of the post-sentence evaluation is to expand upon the pre-sentence evaluation, incorporate relevant treatment issues, and to avoid unnecessary repetition or cost for the offender being evaluated. If there is a conflict between the pre- and post-sentence evaluation findings, the approved provider shall consult with the supervising criminal justice agency for resolution.

II. Required Assessment Instruments

To provide the most accurate prediction of risk for domestic violence offenders, the evaluation shall include at a minimum, the use of instruments that have specific relevance to evaluating domestic violence offenders, and have demonstrated reliability and validity based on published research.

A. Domestic Violence Risk Assessment Instrument(s)

1. Spousal Assault Risk Assessment Guide (SARA)
   If the SARA has been completed by the supervising criminal justice agency, the Approved Provider will obtain a copy to review, and utilizing clinical judgment and impressions adjust the findings, if necessary. Any additional clinical impressions that would modify the risk level of the offender shall be forwarded to the supervising criminal justice agency.
2. If available, other domestic violence risk assessment instruments, which demonstrate similar levels of reliability and validity based on published research may be utilized.

B. Substance abuse screening instrument(s) with demonstrated reliability and validity.

C. Domestic Violence Risk and Needs Assessment Instrument (DVRNA) (Reference *Standard* 5.04).

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

This empirically based instrument is designed to assist in the classification of offenders based on risk and to determine the appropriate intensity of treatment.

III. Required Minimum Content of Offender Interview
The SARA delineates substantive domains of clinical interest in regard to offender assessment and management. A clinical interview structured by an empirically based assessment instrument is the most effective offender evaluation method.[4]

A. Psychosocial history
B. Mental health history and Mini Mental Status Exam or the Colorado Criminal Justice Mental Health Screen. If screening indicates a need for a more in-depth mental health assessment, it shall be performed by a licensed mental health approved provider (Reference Appendix E Section VIII).
C. Substance use history
D. Relationship history, with attention to domestic violence dynamics
E. Motivation for and amenability to treatment (Reference Appendix E Sections II & III)
F. Offender accountability (Reference Appendix E Section I)
G. Responsivity factors (Reference Appendix E Section VI)
H. Criminogenic needs (Reference Appendix E Section IV)

4.09 Required Minimum Reporting Elements for Submittal to the Supervising Criminal Justice Agency:

The purpose of the required written report to the supervising criminal justice agency is to provide a summary of information obtained and to include, at a minimum, the following elements. The report is intended to be brief and concise.

I. Identify sources of information reviewed
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 nonpublic record source. If the victim requests to have his/her input included in the written evaluation, his/her written permission shall be obtained prior to any victim information being included in the evaluation and/or 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 victims 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.

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

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.*

II. Identify instruments utilized such as assessment instruments, screening instruments, mental health, and/or substance abuse evaluation instruments

III. Provide overview of the findings based at a minimum on the following:
- A. Domestic violence dynamics
- B. Review of the DVRNA (Reference *Standard* 5.04)
- C. Level and nature of domestic violence risk as described in terms of scenario development (e.g., likelihood, imminence, frequency, severity, victims, and context).[5]
- D. Offender accountability (Reference Appendix E Section I)
- E. Offender motivation and prognosis (Reference Appendix E Section II)
- F. Criminogenic needs (Reference Appendix E Section IV)
- G. Offender responsivity (Reference Appendix E Section VI)
- H. Specific victim safety issues

IV. Design an offender treatment plan to include at a minimum:
- A. Recommendations shall address victim safety, offender containment, and offender risk reduction.
- B. The initial level for placement in treatment shall be based on offender risk and the DVRNA (Reference *Standard* 5.04 for Levels of Treatment).
- C. Additional supervision/monitoring recommendations shall be based on the clinical evaluation.
- D. For Specific offender population considerations (as defined in *Standard* 10.01), Approved Providers shall utilize all applicable assessment criteria (Reference Appendix B).
- E. In those exceptional cases in which the approved provider discloses that domestic violence offender treatment is inappropriate for an offender as specified in the *Standards*, all of the following shall apply:
  1. Compelling clinical evidence that is well documented; and,
  2. Well document assessment instruments and/or collateral information, and
  3. At a minimum shall meet at least one of the following criteria:
     a. Offender has documentable cognitive impairments and/or developmental disability(s) sufficient to interfere with comprehension of treatment concepts.

[5] 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).

b. Offender has documentable impairments in mental and/or physical functioning sufficient to interfere in the treatment due to chronic mental illness or chronic physical illness.
c. Offender is clinically evaluated as significantly psychopathic and/or unmanageable in the community; based on a history of repeated failures to benefit from treatment and/or repeated non-compliance with criminal justice containment requirements.[6] (Reference Appendix E Section VIII)
d. Offender is clinically evaluated by an approved provider and found to meet **all** of the following criteria:
   (1) Collateral or additional information collected during the evaluation revealed that the offender acted out of fear and self-preservation in the current incident, and
   (2) The offender has no prior documented criminal history; excluding minor violations or violations posing no substantial threat to person(s), animal(s) or property. Also consideration of the age of the offender at time of prior offense(s), circumstances, and other history of similar behavior, and
   (3) The offender has been identified as low risk. If any risk factors have been identified by the DVRNA, the MTT has concluded that those risk factors identified do not indicate a need for domestic violence treatment in this case, and
   (4) Based on clinical evidence, the offender does not have a history of engaging in any of the following: coercion, threat, intimidation, revenge, retaliation, control, or punishment toward the victim in this case or in any other relationship(s).

4. The results related to the exceptional cases in which an offender is determined to be inappropriate for domestic violence offender treatment shall be well documented. The MTT shall develop and report to the court (individually or collectively) alternative treatment plan(s) and/or disposition recommendation(s) that shall include at a minimum: victim safety, offender containment, and offender risk reduction.

4.10 Ongoing Assessments.

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 parameters of how the offender is being monitored for containment and include

[6] Matthew T. Huss, et.al. "Clinical Implications for the Assessment and Treatment of Antisocial and Psychopathic Domestic Violence Perpetrators." Journal of Aggression, Maltreatment & Trauma, 13:1 2006, 59-85.

consultation with the MTT. The results of each assessment shall be added to the offender's treatment plan and contract.

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 incorporate different levels of treatment and focus on offender risk. The length of treatment in these revised *Standards* 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.

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.*

VII. **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: 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.*

VIII. **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 The Domestic Violence Risk And Needs Assessment Instrument (DVRNA)

Placement in treatment shall be determined by the pre-sentence or post-sentence intake 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 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, Division of Behavioral Health (DBH) approved substance abuse screening instrument, offender clinical interview, mental health screen, and other information as required in Offender Evaluation *Standard* 4.05.

The 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.[1]

1. Substance abuse/dependence within the past 12 months [2](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 drugs[3] (Campbell, 1995)

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 V codes)
2. Personality disorder with anger, impulsivity, or behavioral instabili-ty (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. Serious[4] 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)

[1] The DSM-IV-TR refers to "substance dependence" as a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking
[2] The 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
[3] (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
[4] "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.

3. Credible[5] 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 relationships [6] (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 firearms[7] (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 (DVSI, 1998; Buzawa, et al., 2000; Ventura & Davis, 2004). If there have been two or more arrests[8], 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 (Kropp & Hart, 2008; B-SAFER, 2005; ODARA, 2005)
   5. Past assault of 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)

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)

[5] "Credible" as defined in the SARA means that the threats were perceived as credible by the victim.
[6] Jacquelyn Campbell's work cited in this document refers to her work on femicide and only female victims in heterosexual relationships.
[7] Personal ownership of a firearm or living in a household with a firearm.
[8] The DVSI assigns one point for one prior arrest and two points for two or more prior arrests.

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"[9] 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 violence[10] 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 assault [11] (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)

L. Victim separated[12] from offender within the previous six months (DVSI, 1998; Campbell, et al., 2003)

[9] Although the medical terminology is "strangle", victims more readily identify with the word choke when reporting abuse.
[10] In the SARA #1 (Past Assault of Family Members), threatened assault of family members in the past.
[11] 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.
[12] 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.

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).

5.05 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).

II. **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 with the victim and the supervising criminal justice agency, and any other requested releases of information as deemed necessary by the Approved Provider
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).
   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 court ordered domestic violence 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 advocacy 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.

5.06 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.

[1] Refer to chart on page 5-33 entitled “Overview Chart of 5.0 Offender Treatment”

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.

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 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 Approved 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, appear-ance, 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.

5.07 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 of-fender'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.)

5.08 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 Responsibility**[1] (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.

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

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

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).
   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.

5.09 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.
5. Reduction of risk as reported by Approved Provider, using information from other MTT members, and
6. 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.

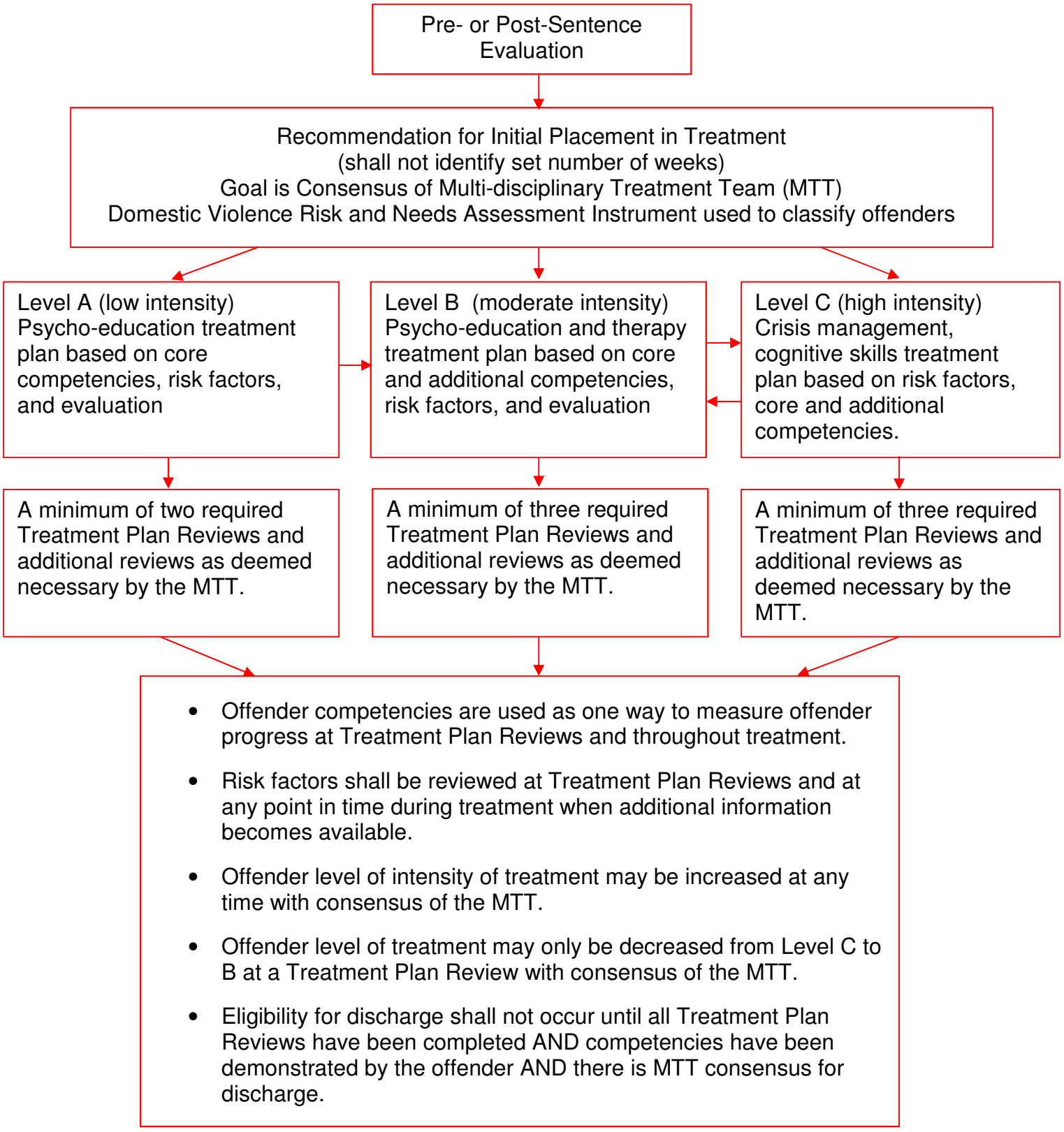
5.10 Couple's Counseling

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.

OVERVIEW CHART
OF
5.0 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 Coordination

7.01 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.

7.02 Victim Advocacy For Court Ordered Domestic Violence Treatment: Approved Providers shall have a treatment victim's advocate providing advocacy as an integral component of their program. The purpose of victim advocacy is to support the victim, advocate for the victim in the treatment program on safety issues and containment, educate the victim on domestic violence and treatment, and provide referrals. Although victim advocacy is considered an integral aspect of offender treatment, the victim may be best served by being referred to a local domestic violence victim's program for services in order to avoid conflict of interest, and due to the expertise of the victim's program on victim's issues.

7.03 Qualifications For Treatment Victim's Advocates Working With an Offender Treatment Program:

a) Treatment victim's advocates shall have 15 hours of training on domestic violence and victimization.
b) If Approved Providers are specializing in a specific population of offenders, the advocates shall have eight hours of training on that specific population.
c) Treatment victim's advocates shall have continuing education.
d) Treatment victim's advocates shall be supervised by an individual who has expertise in domestic violence victim advocacy. Modes of supervision may be provided as described in *Standards* Section 9.04.
e) Treatment victim's advocates shall be violence free.

7.04 Procedures:

a) Ongoing advocacy shall not be provided by the primary Approved Provider for the offender due to dual role, confidentiality, and safety issues. However, all Approved Providers shall have the knowledge and capability to develop a safety plan for a victim.
b) An advocacy agreement shall be created between the treatment victim's advocate and the victim. The treatment victim's advocate shall inform the victim of the information that can be provided during advocacy contacts, such as the offender's treatment evaluation, informing the victim prior to offender discharge from treatment, as well as, resources and information identified in *Standard* Section 7.05. The advocacy agreement shall address the following:

1. Whether or not the victim wishes to be contacted
2. Frequency of contact--how often the victim would like to be contacted)
3. Mode and location of contact - how and where the victim would like to be contacted (e.g. telephone, U.S. mail, at work, email, at home).
4. Type of information the victim wants included in the advocacy contact (e.g. offender status in treatment, offender absences, discharge, or changes in Treatment Plan)

c) The treatment victim's advocate is a member of the MTT and participates in MTT decisions (refer to *Standard 5.02).*

d) Whereas information from the victim is valued, victim safety shall be the first priority. Offender treatment is not contingent on victim contact and the offender shall not be used as a mechanism to reach the victim. The victim shall be contacted except in circumstance where contact may endanger the victim.

e) Attempts to contact the victim need to be made throughout the course of treatment or per the advocacy agreement. Attempts to contact the victim shall be documented.

f) Approved Providers have the duty to warn the potential victim of imminent danger if the provider believes that the victim may be at risk from the offender because of threats made or behavior exhibited.

g) Information on confidential victim statements shall be kept in a file separate from the offender file.

h) The Approved Provider and/or the treatment victim's advocate are responsible for informing the victim of his/her right to choose not to provide information and whether that information may be used as part of the offender's treatment process. Approved Providers shall verify that the treatment victim's advocate has obtained a written release of confidentiality from the victim before victim information can be shared with the offender. Even when the victim gives permission to share information with the offender, the Approved Provider needs to use discretion and consider the victim's safety before using information obtained from the victim. If the victim chooses not to provide information, the Approved Provider shall respect that decision.

7.05 Contact: Information provided to victims shall include, but is not limited to: providing information on domestic violence and treatment, status/participation notification, 24-hour crisis management and safety planning, well-being checks, provider referrals, resources for children and duty to warn. If the Approved Provider or the treatment victim's advocate is meeting face-to-face with a victim, safety issues shall be addressed such as using a different meeting site to ensure the victim will not have contact with the offender.

7.06 Safety Plan: The safety plan is designed to enhance a victim's and his/her children's safety. A safety plan includes the following elements:

a) Information and referrals regarding restraining orders

b) A list of emergency phone numbers of domestic violence victim services, shelters or treatment centers

c) A list of safe places to stay including friends, family, local shelters, and victim services
d) Identification of danger signals that indicate potential violence by the offender
e) Information on the victim's right to apply for Colorado's Crime Victim Compensation Program (§ 24-4.1-105, C.R.S.)
f) Ensure that the victim and all those in caretaker positions for the children have a safety plan for the children (e.g. school/daycare has a copy of the restraining orders, etc.)
g) Strategies for vacating premises safely if the offender attempts to have contact. This includes keeping important papers, personal articles, and cash together, and therefore, ready to be taken as the victim vacates.

Required Approved Provider/Advocate Coordination and Consultation

7.07 Offender 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's Advocate and the referring agency. The Treatment victim's 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.

7.08 Length of Treatment: These standards incorporate different levels of treatment and focus on offender risk. The length of treatment in these revised *Standards* is determined by individual offender risk and progress in treatment. Refer to Overview Chart of Offender Treatment on page 5-38.

7.09 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 (Refer to *Standard* Section 5.06 I and II).

7.10 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.

7.11 Offender Discharge: There are three types of offender discharge. Refer to *Standard* Section 5.09, which identifies each type of discharge; and responsibilities of the offender, MTT, and Approved Provider.

7.12 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.*

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. [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.

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.

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

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

New Applicants
New applicants are those who have never been on the DVOMB Approved Provider List. All new applicants shall meet the following general, educational, experiential, and supervision criteria for approval.

All applicants involved in domestic violence offender treatment must have an Approved Provider as a co-facilitator until approval from the Board is granted.

New applicants who are co-facilitating any domestic violence offender treatment must have supervision in accordance with these Standards.

There are **FOUR** levels of approval for Providers:

- **Entry Level Provider** is an introductory level.

- **Provisional Provider** is designed only for communities with a demonstrated need for a provider. Provisional approval is most often applicable to rural areas and where offender or special populations needs are underserved or unmet. Reference 9.07 for requirements for this type of approval. 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.

- **Full Operating Level Provider** is a Provider who has met all the necessary educational, training, and experiential requirements.

- **DV Clinical Supervisor** is a licensed Full Operating Level Provider who has obtained the additional training and experiential requirements for supervisors and who provides supervision in accordance with the Standards.

9.01 Entry Level Provider Requirements

I. The Entry Level Applicant shall meet all of the following general criteria:

A. Have a Bachelor's Degree or higher in a human services area of study and have 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.

B. Hold a professional mental health license, certification or be listed as a registered psychotherapist with the Colorado Department of Regulatory Agencies (DORA).

C. Submit to a current background investigation in addition to a state and national criminal history record check [(§16-11.8-104(2)(a), C.R.S.]

D. Demonstrate community collaboration with local non-profit victim services, probation offices, and task force (if available).

E. Confirm compliance with the Standards.

F. Shall not have a conviction of a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contendre 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* 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.

II. The Entry Level Applicant shall meet all of the following counseling experiential criteria:

A. Have 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 15 hours of one-to-one supervision for the 300 hours. Applicants with a CAC II or higher or a masters in counseling may demonstrate this with transcripts, licensure or certification.

B. Applicants with a masters degree in counseling or higher shall have 108 face-to-face client contact hours working with domestic violence offenders directly observed by a Full Operating Level Provider or DV Clinical Supervisor. Bachelor degree applicants shall have 216 face-to-face domestic violence offender client contact hours.

These contact hours shall include intake evaluations, co-facilitation of groups, and may include individual treatment sessions and must be obtained in no less than a four-month period. These hours shall be in addition to the 300 general experiential hours identified in item number II. A. of this section.

The applicant and the co-facilitator of these hours shall spend a minimum of two additional hours per month on clinical preparation and clinical review of these experiential hours.

Note: Entry Level Applicants who are Provisional Providers may be eligible to request a variance for the additional co-facilitation hours requirement.

C. Submit a letter of support for approval from the Approved Provider that co-facilitated the face-to-face client contact hours working with domestic violence offenders.

D. Have 25 face-to-face client contact hours providing clinical substance abuse treatment at a Division of Behavioral Health (DBH), formerly ADAD, licensed or comparable program.

III. The Entry Level Applicant shall meet all of the following training criteria:

Applicants who have a masters degree or higher in a counseling related field shall have 77 hours of documented training specifically related to domestic violence evaluation and treatment methods. Master degree applicants shall demonstrate a balanced training history with 21 hours devoted to victim issue subject areas, 28 hours offender evaluation and assessment, and 28 hours offender treatment facilitation and treatment planning. Bachelor applicants shall have all of the 77 training hours plus 35 hours of basic counseling skills training.

Domestic Violence Victim Issues- **21** training hours required from these topic areas:

- 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
- Safety planning
- Victim dynamics to include obstacles and barriers to leaving abusive relationships
- Trauma issues

Offender Evaluation and Assessment Specific to Domestic Violence - **28** training hours required from these topic areas:

- 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 - **28** training hours required from these topic areas:

- 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

Basic Counseling Skills: **bachelor degree level applicants** - 35 hours required
(Applicants with a masters degree in a counseling related field, or CAC II or higher do **not** need to demonstrate these training hours.)

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

IV. Supervision Requirements for **Entry Level Applicant**

Applicants are required to have DV clinical supervision for a minimum of 1 hour per month for up to 10 client contact hours, and 2 hours per month for 10 or more client contact hours or additional supervision as determined by the DV Clinical Supervisor. Applicants who are not providing direct services to offenders may request an exception to the supervision requirement.

A. The appropriate modality for supervision shall be determined by the DV Clinical Supervisor based upon the training, education, and experience of the supervisee, as well as the treatment setting. Factors that shall be considered are community standards and offenders' needs, urban versus rural setting, and availability of resources. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, audio/videotape, teleconferencing, and Internet). If supervision is electronic, face-to-face supervision shall occur on no less than a quarterly basis.

B. The treatment victim advocate shall be included as part of supervision or staffing for Approved Providers at least quarterly.

V. Supervision Requirements for **Entry Level Approved Providers**

A. Licensed and unlicensed Approved Providers are required to have clinical supervision for a minimum of two hours per month or more as determined appropriate with a DV Clinical Supervisor. One hour shall be individual and one hour may be group supervision. Providers in rural areas that demonstrate need may request of the Board the use of an additional modality (such as telephone, audio/ video, videoconferencing, or by the Internet). Additional supervision requirements shall be based on education, training, workload, and experience of the supervisee; the treatment needs of the offender; and the professional judgment of the DV Clinical Supervisor.

B. The appropriate modality for supervision shall be determined by the DV Clinical Supervisor based upon the training, education, and experience of the supervisee, as well as the treatment setting. Factors that shall be considered are community standards and offenders' needs, urban versus rural setting, and availability of resources. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, audio/videotape, teleconferencing, and Internet). If supervision is electronic, face-to-face supervision shall occur on no less than a quarterly basis.

C. The treatment victim advocate shall be included as part of supervision or staffing for Approved Providers at least quarterly.

VI. Continued Placement for Approved Entry Level Providers.

A. Since Entry Level is an introductory approval level, the provider's plan for progressing to Full Operating Level shall be reviewed with their DV Clinical Supervisor at least once a year.

B. Continuing Education for Entry Level providers shall consist of the completion of 14 clock hours every year in topic areas relevant to improved treatment with court ordered domestic violence offenders. Of the 14 hours, at least 7 shall be on victim issues and the balance on training requirements for Full Operating Level approval.

C. All Approved Providers shall reapply for continued placement as determined by the Board. Providers can remain at Entry Level but are encouraged to apply for the next level.

9.02 Full Operating Level Provider Requirements

Application for full operating provider can be made after all general, educational, training, and experiential requirements have been met.

I. The Full Operating Level Applicant shall meet the following general criteria:

A. Have a bachelors degree or higher in a human services area of study. 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, ~~or~~ certification or be listed as a registered psychotherapist with the Colorado Department of Regulatory Agencies (DORA).

C. Submit to a current background investigation in addition to a state and national criminal history record check [(§16-11.8-104(2)(a), C.R.S.]

D. Shall not have a conviction of a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contendre 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* 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.

II. The Full Operating Level Applicant shall meet all of the following counseling experiential criteria:

A. Have 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. Applicants with a CAC II or higher or a masters in counseling may demonstrate this with transcripts, licensure or certification.

B. Applicants with a masters degree or higher in a counseling related field shall have 162 hours of face-to-face client contact hours working with domestic violence offenders directly observed by a Full Operating Level Provider or DV Clinical Supervisor. Bachelor degree applicants shall have 324 hours of face-to-face client contact hours working with domestic violence offenders directly observed by a Full Operating Level Provider or DV Clinical Supervisor.

Of these 162/324 hours, 20% shall include co-facilitation of offender treatment groups. The additional required hours may include intake evaluations, co-facilitation of groups, and individual treatment sessions.

The applicant and the co-facilitator of these hours shall spend a minimum of two additional hours per month on clinical preparation and clinical review of these experiential hours.

Applicants with a bachelor's degree shall obtain the 324 hours of co-facilitation in no less than a six-month period.

C. Have 50 face-to-face client contact hours providing clinical substance abuse treatment at a Division of Behavioral Health (DBH), formerly ADAD, licensed or comparable program.

III. The Full Operating Level Applicant shall meet all of the following training criteria:

Master degree level applicants shall have 154 hours (bachelor level applicants shall demonstrate 203 hours) of documented training specifically related to domestic violence evaluation and treatment methods. All applicants shall demonstrate a balanced training history with 21 hours of legal issues, 35 hours devoted to victim issue subject areas, 49 hours offender evaluation and assessment, and 49 hours offender facilitation and treatment planning. Bachelor applicants shall also demonstrate 49 hours of training on basic counseling skills.

<u>Legal Issues (21)</u>

- 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 Issues (35 hours required from these topics areas:)

- 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
- Safety planning
- Victim dynamics to include obstacles and barriers to leaving abusive relationships
- Trauma issues

Domestic Violence Offender Evaluation and Assessment (49 hours required from these topics)

- Clinical interviewing skills with domestic violence offenders
- 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 (see appendix/glossary)

Facilitation and Treatment Planning (49 hours required from these topics)

- Substance abuse and domestic violence
- Offender self management
- Motivational interviewing
- Provider role in offender management and containment
- Forensic psychotherapy
- Coordination with criminal justice system
- Offender accountability (see appendix/glossary)
- Recognizing and overcoming offender resistance (see appendix/glossary)
- Offender contracts
- Ongoing assessment: skills and tools
- Offender responsivity to treatment (see appendix/glossary)
- Diversity/cultural competency
- Personality Disorders
- Learning Styles
- Levels and competencies

Basic Counseling Skills (49 hours required)
(Applicants with a masters degree in a counseling related field, or CAC II or higher do **not** need to demonstrate these training hours)

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

IV. Supervision requirements for **Full Operating Level Applicants**:

Applicants are required to have DV clinical supervision for a minimum of 1 hour per month for up to 10 client contact hours, and 2 hours per month for 10 or more client contact hours or additional supervision as determined by the DV Clinical Supervisor.

V. Supervision/Peer Consultation requirements for **Full Operating Level Providers:**

A. All Approved Full Operating Level Providers, licensed and unlicensed, are required to have peer consultation with another approved Full Operating Level Provider for a minimum of two hours per month.

B. The treatment victim advocate shall be included as part of supervision or staffing for applicants and approved providers at least quarterly.

VI. Continued Placement for Full Operating Level Providers

A. Continuing Education for Full Operating Level Providers shall consist of the completion of 28 hours every two years in topic areas relevant to improved treatment with court ordered domestic violence offenders. Of the 28 hours, diversity and victim issues shall be included.

B. All approved providers shall reapply for continued placement as determined by the Board.

9.03 Domestic Violence Clinical Supervisor Qualifications

I. The Applicant shall meet all of the following criteria in addition to all requirements for Full Operating Level Approved Provider (9.02)

A. Hold a professional mental health license from the Colorado Department of Regulatory Agencies (DORA). Certifications do not meet the requirement.

B . 49 hours of training specific to substance abuse and addiction

C. 21 hours of training in clinical supervision. If applicant does not have experience providing general clinical supervision within the past five (5) years, then these training hours must be accrued within the past five (5) years.

D. 75 hours of face-to-face client contact working with domestic violence offenders with a minimum of one (1) year of DV treatment provision at the Full Operating Level.

E. 100 hours of providing general clinical supervision during the past five years or obtain ongoing consultation regarding supervision issues until these 100 hours are obtained (minimum of one hour of supervision per month, electronic means are acceptable)

F. Confirm knowledge of the Board Application Policies pertaining to responsibilities of DV Clinical Supervisors. Misrepresentation by a DV Clinical Supervisor on behalf of an applicant will be grounds for complaint filing with Department of Regulatory Agencies.

II. Peer Consultation Requirements:

A. DV Clinical Supervisors are required to have a minimum of two hours per month of peer consultation 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.

B. For rural areas peer consultation may include electronic modes of consultation (such as telephone, audio/videotape, teleconferencing, and Internet). If electronic modes of consultation are utilized, face-to face consultation shall occur on no less than a quarterly basis.

III. Continued Placement for DV Clinical Supervisor

A. Continuing Education for DV Clinical Supervisor shall consist of the completion of 28 hours every 2 years in topic areas relevant to improved treatment with court ordered domestic violence offenders. Of the 28 hours, diversity and victim issues shall be included.

B. All approved providers shall reapply for continued placement as determined by the Board.

9.04 Content of Clinical Supervision and Peer Consultation

Supervision shall include, but not be limited to, these areas:

I. Discussion of case coordination with victim, victim advocate, and/or victim's therapist
II. Discussion of services provided by the supervisee
III. Discussion of treatment plans, intervention strategies, and evaluations of offender's progress
IV. Administrative procedures of the practice as they relate to clinical issues
V. Discussion of ethical issues
VI. Evaluation of supervisory process, including performance of the supervisor and supervisee
VII. Coordination of services among other professionals involved in particular cases, such as probation, criminal justice, and victim service agencies
VIII. *Colorado Standards for Treatment with Court Ordered Domestic Violence Offenders*
IX. Relevant Colorado laws and rules and regulations, including confidentiality and duty to warn
X. Discussion of offender resistance, transference, and counter-transference issues

Note: The treatment victim advocate shall be included as part of supervision or staffing for applicants and approved providers at least quarterly.

9.05 Evaluators

Approved providers may choose to evaluate offenders and not provide any other direct services for offenders. These providers shall comply with the evaluation standards identified in Section 4.0. Additionally, they shall comply with supervision and continuing education requirements.

9.06 Specific Offender Populations

Approved providers working with specific offender populations as defined in Standard 10.01 shall comply with all requirements identified in Section 10.

9.07 Provisional Approval

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 approved providers. Provisional approval is most often applicable to rural areas and/or where a community's needs are underserved or unmet.

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 approval is granted at the discretion of the Board. Provisional approval requirements are as follows:

I. The Provisional Applicant shall meet all the general criteria listed in Section 9.01 I.

II. The Provisional Applicant shall demonstrate community need for offender treatment that cannot be met by existing approved providers by:

   A. 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.

III. The Provisional Applicant shall meet the following counseling experiential hours:

   A. Have 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 15 hours of one-to-one supervision for the 300 hours. Applicants with a CAC II or higher or a masters in counseling may demonstrate this with transcripts, licensure or certification.

   B. Have 108 face-to-face client contact hours working with domestic violence offenders directly observed by a Full Operating Level Provider or DV Clinical Supervisor (54 face-to-face hours for applicants with a masters degree in counseling with a minimum of 1000 hours post graduate counseling experience). These contact hours shall include intake evaluations, co-facilitation of groups, and may include individual treatment sessions and must be obtained in no less than a four-month period. These hours shall be in addition to the 300 general experiential hours.

The applicant and the co-facilitator of these hours shall spend a minimum of at least one additional hour per month on clinical preparation and clinical review of these experiential hours.

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

Applicants who have a **masters degree or higher in a counseling related field** shall have 35 hours of documented training specifically related to domestic violence evaluation and treatment methods. Master degree applicants shall demonstrate a balanced training history with 14 hours devoted to victim issue subject areas, 14 hours offender evaluation and assessment, and 7 hours offender treatment facilitation and treatment planning. Bachelor degree applicants shall have 70 **TOTAL** hours, 35 hours in these same training areas plus 35 hours of training in basic counseling skills.

Domestic Violence Victim Issues - **14** training hours required from these topic areas:

- 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
- Safety planning
- Victim dynamics to include obstacles and barriers to leaving abusive relationships
- Trauma issues

Offender Evaluation and Assessment Specific to Domestic Violence - **14** training hours required from these topic areas:

- 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 - **7** training hours required from these topic areas:

- 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

Basic Counseling Skills **bachelor degree applicants** (35 hours required) (Applicants with a masters degree in a counseling related field, or CAC II or higher do not need to demonstrate these training hours)

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

V. Supervision and Peer Consultation Requirements for Provisionally Approved Provider or Applicant:

A. Provisional Level licensed and unlicensed applicants and approved providers are required to have clinical supervision for a minimum of 1 hour per month of DV clinical supervision for up to 10 client contact hours, and 2 hours per month for 10 or more client contact hours (two hour minimum if the provider has more than two groups) or additional supervision as determined by supervisor. At least one hour quarterly shall be individual supervision and the other hours may be at any additional modality (such as telephone, audio, videotape, videoconferencing, or by the Internet).

B. Supervision for applicants shall include training on offender evaluation and assessment.

C. Provisional Level providers who are also licensed mental health providers are eligible for peer consultation rather than supervision requirements beginning their 2nd year of practice. A letter of recommendation is required from the clinical supervisor.

D. Provisional Level providers are required to submit quarterly progress letters from the supervisor and victim advocate.

E. The treatment victim advocate shall be included as part of supervision or staffing for applicants and approved providers at least quarterly.

VI. Continued Placement for Provisional Level providers.

A. Continuing Education for Provisional providers shall consist of the completion of 14 clock hours every year in topic areas relevant to improved treatment with court ordered domestic violence offenders. Of the 14 hours, at least 7 shall be on victim issues and the balance on training requirements for Full Operating Level approval.

B. All approved providers shall reapply for continued placement as determined by the Board. Providers can remain at Provisional but are encouraged to apply for the next level.

This chart does not reflect every requirement; it is only a summary of these areas, Reference 9.0

Requirement	Provisional	Entry Level	Full Operating	DV Clinical Supervisor
DV Specific Training Hours	MA – 35 hrs. BA – 70 hrs.	MA – 77 hrs. BA – 112 hrs.	MA – 154 hrs. BA – 203 hrs.	No additional training hours beyond Full Operating Level
DV Experiential Hours (co-facilitation of dv treatment with approved provider)	MA with 1,000 post graduate general clinical hours requires 54 hrs. MA with less than 1,000 post graduate general clinical hours or BA requires 108 hrs. (36 weeks x 1.5 hr group = 54 hrs.)	MA – 108 hrs. BA – 216 hrs. (54 hrs. x 2 groups = 108 54 hrs. x 4 groups = 216)	MA – 162 hrs. BA – 324 hrs. (54 hrs. x 3 = 162 54 hrs. x 6 = 324)	75 hrs. in addition to Full Operating Level requirement
Supervision (Supervisor or staffings shall include victim advocate at least quarterly)	A minimum of 1 hr. per month of DV clinical supervision for up to 10 client contact hours, and 2 hrs. per month for 10 or more client contact hrs. or additional supervision as determined by supervisor. Licensed provisional providers are eligible to do peer consultation rather than supervision beginning their 2nd year of practice.	A minimum of 2 hrs. per month of DV clinical supervision or additional supervision as determined by supervisor. (Variance may be requested for rural areas.) Applicants may have less if small caseload.	Minimum of 2 hrs. per month of peer consultation required for all providers at this level, no clinical supervision required. (Applicants are required to have supervision based on size of caseload.)	Minimum of 2 hrs. per month of peer consultation required with another approved and licensed provider.
Continuing Education	14 hours per year	14 hours per year	28 hours every 2 yrs	28 hours every 2 yrs.
Additional/Special requirements	Eligibility – Only for communities that demonstrate need, such as no existing provider, approval is only for that community. A letter of support for approval from the provider that co-facilitated treatment.	None	None	Licensed mental health professional 21 hrs. training in clinical supervision within past 5 yrs.
	MA = masters degree in counseling related field BA = bachelors degree in human services related field Providers may remain at the Provisional or Entry Levels but are encouraged to apply for the next level once qualifications are met.			

10.0 Specific Offender Populations

10.01 Definition: 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 homogenous.

10.02 Documentation Requirements:

a) Approved providers shall submit a statement that addresses how their interventions are appropriate for specific offender populations.
b) Approved providers who intend to provide treatment for a specific offender population shall submit documentation of training and experience as identified in *Standards* 10.03, 10.04 and 10.05. Approved providers shall also submit evidence that their program is in compliance with any treatment and assessment criteria identified by the Board for that specific offender population.

Training, Experiential and Supervision Requirements

10.03 Training Hours: If an approved provider identifies a specific offender population as a focus of treatment, the provider shall be required to have a minimum of 14 hours of specialized training specific to that population. The 14 hours is in addition to training required under *Standards* 9.02 and 9.03.

10.04 Experiential Hours: If an approved provider is applying for approval to work with a specific offender population as defined in *Standard* 10.01, the approved provider shall have 50 face-to-face client contact hours with that population. These hours can be with both offender and non-offender populations. If an approved provider does not have 50 face-to-face client contact hours with that population, the approved provider shall demonstrate expertise with this population and detail how that expertise was gained.

10.05 Supervision: If an approved provider is specializing with a specific offender population as defined in *Standard* 10.01, the approved provider shall obtain a percentage of the required supervision equal to the percentage of that population seen from a clinician who has expertise with this population. (For example, if 50 percent of client contact hours is with a specific offender population, then 50 percent of the supervision shall be from a clinical supervisor who has expertise with that population.)

10.06 Offender Treatment Goals: The treatment goals, in addition to those identified in *Standard* 5.13, should be designed to encompass the needs of specific offender populations. Approved providers shall follow treatment and assessment criteria identified by the Board for that specific offender population.

10.07 Gender: All treatment groups and content shall be gender specific.

10.08 Sexual Orientation: All treatment groups shall be specific to sexual orientation and gender identity. If group treatment is not available, the offender shall be seen individually or referred to an approved provider that has such a group available. If

individual treatment is utilized, the approved provider shall follow guidelines identified in *Standard* 5.03III with the continuing goal of referring to a group whenever possible. In addition, the approved provider shall meet the qualifications and have the required supervision (Sections 10.03, 10.04 and 10.05). If there is no approved provider in the community qualified to work with this population, the approved provider may, in the interim, provide services. Additionally, the approved provider shall have a supervisor who meets the specific offender population qualifications. Furthermore, the approved provider shall consult monthly with other approved providers who are qualified to work with this specific population.

10.09 Language: Whenever possible, approved providers shall provide treatment in the offender's primary language. If the approved provider does not speak the offender's primary language, the approved provider will refer the offender to a program that provides treatment in the offender's primary language. If no such 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.

10.10 Offenders With Disabilities or Special Needs: Approved providers shall assess for disabilities or special needs of offenders and accommodate these to the best of their ability. If the approved provider is unable to accommodate these needs, he/she will refer the offender to another approved provider. If no alternative approved provider is available, 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.

11.0 Administrative Standards

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

11.02 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 contendre 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.

11.03 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.

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

11.05 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 court ordered domestic violence evaluation and treatment services based on a sliding scale fee. (see Glossary)

11.06 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 court ordered 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.

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

11.08 Release of Information: The Approved Provider shall obtain signed releases of information from the offender for the following persons: victim(s) of record, current partner, treatment victim's advocate, the responsible criminal justice agency, and the Board (for the purposes of research related to evaluation or implementation of the

Standards or domestic violence offender management in Colorado). Other releases of information may include the offender's former partner(s), current and/or past therapist or Approved Provider, and where warranted, any guardian ad litem, human services worker, or other professional working on behalf of the adult and child victims of the offender. The approved Provider shall document any exceptions to this standard.

11.09 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.

11.10 Child Abuse and Neglect: Approved Providers are required by law to report child abuse and/or neglect according to statute Section 19-3-304, C.R.S.

11.11 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*.

11.12 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.

11.13 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, program materials, and any additional treatment locations.

11.14 Approved Provider Audit: The Board may audit an Approved Provider for compliance with *Standards* 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.

11.15 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.

11.16 Violations of Standards: Violations of these S*tandards* may be grounds for action by the Board pursuant to Section 16-11.8-103, C.R.S.

11.17 Variances: An Approved Provider may request a variance to the *Standards* 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 areas.

12. Appendices

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

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

I. Domestic Violence Offenders in Same-Sex Relationships
II. Female Domestic Violence Offenders

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Appendix A:

DVOMB Statement Regarding the Evaluation and Treatment of Non-court Ordered 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 DV Treatment Standards. 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 DV treatment Standards 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 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 do not specifically** reflect awareness or sensitivity to differences within specific offender populations. **These appendices are intended to supplement the Standards 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 Court-Ordered 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 approved *Standards for Treatment for Court Ordered Domestic Violence Offenders* 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)
4. 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.
5. Unique sexual activity history
6. Gender stereotypes in relationship(s)
7. Unique health issues (e.g., HIV, cancer, hepatitis, STD)
8. Current offense/arrest information: level of aggression (predominant aggressor vs. co-combatant vs. true victim)
9. Level of internalized homophobia
10. Stage of LGBTQ socialization
11. Stage of coming out
12. Level of acceptance/rejection: family, friends, employer, landlord
13. Level of access to LGBTQ support resources
14. Unique stalking concerns
15. 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?

16. Anger assessment: behaviors when angry; "triggers" for anger; emotional volatility
17. Rape, sexual abuse history, childhood history of victimization
18. Current offense/arrest information: level of aggression (predominant aggressor vs. co-combatant vs. true victim)
19. 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 safe houses)
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. **Transvestite:** More appropriately referred to as "crossdressing," the term transvestite most often refers to males who dress in the clothing of women. The term drag usually refers to dressing in the clothing and styles of another gender for entertainment purposes.
8. **Transsexual:** Transsexual is used to describe those individuals who use hormone therapy and/or surgery to alter their sex.

9. **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:** Ones 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 Court-Ordered 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 approved *Standards for Treatment for Court Ordered Domestic Violence Offenders* 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, sex work)
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 CRS 18-6-803.6)
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

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

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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

ADAD: [See DBH (Division of Behavioral Health)]

Aftercare Plan: An offender's written plan for utilizing concepts learned in treatment. This plan shall include ways to maintain continued sobriety and continued pro-social support systems, and to maintain mental health needs.

Approved Provider: An individual who advertises or sets him/herself forth as having the capacity, knowledge, and training to evaluate and/or treat court ordered domestic violence offenders 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 the application process for specific offender populations.

Board: As defined in Section 16-11.8-102, C.R.S.

Clock Hours: 60 minutes in an hour.

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: They represent the goals of treatment to be measured at Treatment Plan Reviews. 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.

Containment Group: Those involved in the containment of a specific domestic violence offender. These persons may include supervising agents of the court (in some instances may be more than one agent of the court), the court, and Approved Providers in conjunction with the victim advocate.

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.

DBH: The Division of Behavioral Health, formerly 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. DBH's address and phone number is as follows: Colorado Department of Human Services, Division of Behavioral Health, 3824 West Princeton Circle., Denver, Colorado, 80236, 303-866-7400.

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.

DPS: Department of Public Safety is responsible for staffing the Board pursuant to Section 16.11.8-103, C.R.S.

Domestic Violence: The term is defined in Section 18-6-800.3(1), C.R.S. and is expanded to include the following definitions for the purpose of the approved provider's use in treatment:
a) Physical violence: aggressive behavior including but not limited to hitting, pushing, choking, scratching, pinching, restraining, slapping, pulling, hitting with weapons or objects, shooting, stabbing, damaging property or pets, or threatening to do so.
b) Sexual violence: forcing someone to perform any sexual act without consent.
c) Psychological violence: intense and repetitive degradation, creating isolation, and controlling the actions or behaviors of another person through intimidation (such as stalking or harassing) or manipulation to the detriment of the individual.
d) Economic Deprivation/Financial Abuse: use of financial means to control the actions or behaviors of another person. May include such acts as withholding funds, taking economic resources from intimate partner, and using funds to manipulate or control intimate partner.

Domestic Violence Clinical Supervisor: An approved provider who meets the qualifications identified in *Standard* 9.18

DORA: The Department of Regulatory Agencies, Division of Registrations 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. DORA's address and phone number are as follows: 1560 Broadway, Suite 1350, Denver, Colorado 80202 303-894-7800
DSM: The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Evaluator: An Approved Provider who conducts ~~a~~ post-sentence intake evaluations. If the Approved Provider conducts the pre-sentence evaluation, he/she shall also be a licensed mental health professional.

Face-to-Face Client Contact Hours: The actual time that an applicant or approved provider spends with a client/offender providing assessments/evaluations, individual, group, couple's, or family therapy.

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

Offender: As defined in Section 16-11.8-102, 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 Containment: The process of restraining, halting or preventing the offender from further violence against an intimate partner through consequences and restrictions imposed by the Coordinated Community Response.

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

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.

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

SARA: The Spousal Assault Risk Assessment tool created by P. Randall Kropp and Stephen D. Hart includes a clinical checklist of 20 risk factors for spousal assault.

SCAO: State Court Administrator's Office performs duties pursuant to Section 13-3-101, C.R.S.

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 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.

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

Supervising Agents: Those agents of the court including but not limited to private probation and state probation that supervise offenders for the court. In some cases the court itself is the only supervising agent.

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

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 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).

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.

Treatment Victim Advocate: The person who works in conjunction with the Approved Provider and the domestic violence community to provide advocacy to the victim

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

Victim Advocate: See Treatment Victim Advocate.

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Appendix D:

ADMINISTRATIVE POLICIES
DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD
Adopted 9/13/2013

I. DEFINITIONS

A. APPLICATION REVIEW COMMITTEE (ARC)

The Application Review Committee (ARC) is authorized by the Domestic Violence Offender Management Board (DVOMB) within the Division of Criminal Justice (DCJ) to review new applications, additional applications, Renewals, and Re-applications for Re-placements to determine whether an applicant or Provider shall be placed on the Approved Provider List, denied initial placement or denied continued placement. The ARC shall follow DVOMB policies and procedures.

B. EMERGENCY ACTION

In the event of a public safety issue, the ARC Chair Person in conjunction with the DVOMB Program Manager may remove a provider from the Approved Provider List (List), inform law enforcement and/or DORA of an issue.

C. OPEN MEETINGS

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

D. EXECUTIVE SESSION

The members of the DVOMB, or its 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 (C.R.S. §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))

E. LEVELS

There are four levels of approval for the Approved Provider List (List):

- Provisional
- Entry
- Full Operating
- DV Clinical Supervisor

Approved Providers (Providers) who work with specific offender populations shall demonstrate to the Domestic Violence Offender Management Board (DVOMB) that they have fulfilled the requirements for working with these populations according to the Standards, Section 10.0.

F. TYPES OF APPLICATIONS

1. New Applications: for applicants who have never been on the Approved Provider List (Provider List) and who wish placement at the Entry Level, Full Operating Level, or Provisional Level,

2. Additional Applications: for those applicants who have been approved on the Provider List and wish to become a DV Clinical Supervisor or to add specialties in treating specific populations..

3. Re-Application for Re-placement on the List: for applicants who are not currently on the List, but who were formerly on the List and are requesting re-placement on the List.

   Providers who were removed from the Provider List due to *Standards* violations and/or DORA discipline shall submit a Re-Application for Re-Placement Application and if approved, shall provide treatment at Entry Level for at least six months before being permitted to apply for Full Operating Level. Exception: if a Provider is removed from the List solely because of a lapse in their DORA license, registration or certification, then the Provider may be re-placed on the List without submitting fees or a Re-placement application once the DORA license, registration or certification has been verifiably restored.

4. Biennial Renewal for Continued Placement: all Providers who are currently on the Provider List including "Not Currently Practicing" are required to renew their placement on the list every two years in the odd numbered years. At a single date determined by the DVOMB, all Providers will be advised 60 days in advance of the renewal deadline.

G. PROVIDER AND APPLICANT STATUS

1. Approved- the applicant has been approved by the ARC and the provider appears on the DVOMB Approved Provider List

2. Denied- any applicant or Provider who is denied placement on, or removed from the List, shall not provide any services in Colorado to court ordered domestic violence offenders.

3. Removed from the Provider List: the provider has been denied continuing placement on the Approved Provider List OR has requested to be removed from the Provider List.

4. "Not Currently Practicing" means that the Provider remains on the Provider List; however, is not providing any of the following services: court-ordered domestic violence offender treatment, including not performing evaluations and not providing peer consultation or clinical supervision. "Not Currently Practicing" status is requested by the Provider.

II. THE APPROVED PROVIDER LIST

The Approved Provider List is a list of providers authorized to provide treatment to court ordered domestic violence offenders in Colorado. The DVOMB is responsible for approving providers and maintaining an accurate and up to date list pursuant to Title 16, Article 11.8 of the Colorado Revised Statutes.

A. MAINTENANCE OF LIST

1. DVOMB staff shall maintain an accurate List on the Division of Criminal Justice website. Paper copies will be provided and distributed upon request.
2. Notice of providers added to or removed from the List will be provided to: the Department of Regulatory Agencies, the State Court Administrators Office/Division of Probation Services, the Department of Public Safety, the Department of Human Services and Department of Corrections.

B. UPDATES

1. It is the Provider's responsibility to provide updated information to the DVOMB regarding name, address, phone, email and agency changes.
2. Individuals on the provider list shall notify the DVOMB in writing within 10 days of any arrest, conviction, nolo contender plea, or deferred judgment (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor or felony. The DVOMB will be updated by the Colorado Bureau of Investigation 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 an individual should continue to be a listed Provider.

III. PROVIDER APPLICATIONS

Applications and renewal forms are available on the Division of Criminal Justice (DCJ) website at http://www.dcj.state.co.us/odvsom. Copies are distributed upon request at no charge to the Applicant/Provider. Applicants will not be considered Providers nor have "Approved Status" during the Application or Re-Placement review process. The DVOMB may periodically contact the Department of Regulatory Agencies (DORA) regarding an applicant or Provider's licensure or certification status.

A. TIME LIMIT

Due to the time sensitive nature of some of the application requirements (such as the investigation and letters from advocate, supervisor, and community letters of support), all applicants that have not met all the requirements within eight months will be denied. In the event of a denial:

a) Portions of the application that the applicant submitted may be returned to the applicant.

b) Application fees are non-refundable.

c) If the ARC is experiencing a delay in processing an application, they may extend the initial time limit of eight months.

B. CONFIDENTIALITY OF PROVIDER AND APPLICANT FILES

1. CONFIDENTIAL ELEMENTS- The following information in Applicant and Provider files is considered confidential information and not available to the public:

    - Background investigations
    - Criminal history checks
    - School transcripts
    - Letters of reference
    - Trade secrets, privileged information, confidential commercial data such as: Applicant or Provider forms created for business use, curriculum developed for business use and clinical evaluations
    - Information that, if disclosed, would interfere with the deliberative process of the Application Review Committee (ARC) and if disclosed to the public, would stifle honest participation by the ARC (notes from ARC meetings, ARC comments on checklists)

2. COLORADO OPEN RECORDS ACT- Title 24-72-201, C.R.S. applies to other materials.

3. BACKGROUND CHECKS- 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.

C. FEES

The DVOMB assesses application fees to cover the costs of processing applications. Refer to *"The Application Fee Schedule"* for the exact fee schedule.

1. APPLICATION FEES**-** The DVOMB may assess a fee to a person who applies for initial placement or renewed placement on the List not to exceed $300 per application to cover the costs associated with the initial application review and the renewal process pursuant to Section 16-11.8-103 (4) (b) (III) and other costs associated with administering the program.

2. FINGERPRINT FEES- Applicant must use the fingerprint cards that are supplied by the DVOMB. Applicants are required to submit a money order made payable to "Colorado Bureau of Investigations" (CBI) to cover the costs charged by CBI.

D. BIENNIAL RENEWALS

Providers who are compliant with the renewal process will remain on the Provider List throughout the renewal process.

1. REQUIRED BIENNIAL RENEWALS - All Providers shall be required to renew their placement on the List in odd years every two years. Providers who have been newly approved on or after August 1st of the year preceding the next Biennial Renewal deadline are exempt from Biennial Renewal fees and CEU requirements. All other Biennial Renewal information must be submitted. They will be subject to all fees and CEUs for subsequent Biennial Renewals.

2. EXTENSIONS
   a) Providers may request an extension prior to the due date of their Biennial Renewal. The Provider shall demonstrate in writing the need for an extension. Providers will be notified in writing of the decision.

3. FAILURE TO RENEW - Providers who do not comply with the Biennial Renewal process shall be notified in writing that their approval has lapsed, that they may no longer provide services to convicted DV offenders, and that they are removed from the List.

IV. RECONSIDERATION AND APPEAL

Applicants denied placement on the list will be provided with *Procedures for Reconsideration Of Denial and Appeal of Denial (*hereafter Procedures*).* Applicants must be able to demonstrate that they meet the requirements described in the Procedures.

A. **ARC RECONSIDERATION OF DENIAL** is a subsequent review by the ARC of its initial decision to deny an Applicant or Approved Provider (Provider) placement or Continued Placement on the Approved Provider List (List).

B. APPEAL OF DENIAL TO THE DVOMB is when an applicant or Provider submits a written Appeal to the DVOMB regarding the ARC's decision to deny placement on the List or to deny continued placement on the List.

V. THE QUALITY REVIEW ASSURANCE (QAR) PROCESS

The purpose of the QAR is to ensure that Approved Providers operate in accordance with all applicable *Standards for Treatment with Court Ordered Domestic Violence Offenders* and to identify innovative and exceptional practices in the area of domestic violence offender treatment.

A. **CONDUCTING THE QAR**

1. The ARC will conduct Quality Assurance Reviews (QAR) of Providers according to the procedures contained in the DVOMB document, "*Policy Quality Assurance Review Approved Domestic Violence Treatment Providers."*
2. The QAR may be conducted at any time.
3. Providers will receive a QAR packet from the ARC with complete instructions.

B. **QAR REVIEW-** Once the ARC reviews the completed QAR packet, the Provider will be notified in writing regarding the results of the review and whether he or she has been granted continued placement on the List. The results of the review will be as follows:

1. The Provider is approved for continued placement, OR
2. If there are barriers to compliance with the Standards:
    a. The Provider is offered a Compliance Action Plan in lieu of being removed from the List, *or*
    b. The ARC determines that remediation is not feasible and the Provider is removed from the List.
3. If an innovative practice is identified, the ARC will request permission from the Provider to share the practice,

VI. PRACTICES THAT VARY FROM THE STANDARDS

When an Approved Provider (Provider) or new Applicant is faced with barriers to implementing the Standards, he or she may submit a variance proposal to the ARC for feedback. There are two categories of variances: A. Offender Alternative Treatment, as per *Standards, Section 11.17* that refers to issues such as economic hardship, geographic limitations or special needs of client populations specific to an agency or jurisdiction, and B. the Judicial Rural Initiative Application.

A. OFFENDER ALTERNATIVE TREATMENT VARIANCE

To receive approval to modify treatment, providers must submit an offender alternative treatment proposal.

B. JUDICIAL RURAL INITIATIVE APPLICATION

Refer to the *Judicial Rural Initiative Procedure*.

VI. COMPLAINTS

Formal complaints are handled by the Department of Regulatory Agencies (DORA). Formal complaints are either against the certification, license or registration of a DVOMB Approved Provider, or against the certification, license or registration of an individual who is providing or has provided court ordered domestic violence offender treatment without DVOMB approval. DORA will notify the DVOMB of a pending complaint. DVOMB staff, on behalf of, and in consultation with, the ARC, will provide input regarding any alleged violations of the *Standards* for the respective DORA board.

A. SUBMITTING A COMPLAINT

1. DORA receives complaints at:

   Colorado Department of Regulatory Agencies (DORA)
   Mental Health Section
   1560 Broadway, Suite 1350
   Denver, CO 80202
   (303) 894-7800
   www.dora.colorado.gov/professions

2. Complaints must be submitted in writing.

3. A written complaint may be submitted first to the DVOMB. DVOMB Staff will advise the complainant that the complaint will be forwarded to DORA.

4. Complaints may be submitted anonymously. However, complainants who choose to be anonymous need to be aware that they will be ineligible to receive any status information related to the complaint.

5. The DVOMB may initiate a complaint against a Provider. Documentation will be submitted to DORA for processing by the appropriate DORA mental health board.

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

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 for Treatment With Court Ordered 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 (DVSI), 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 sectored 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 V codes)
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 relationships [1] (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 Ruisk 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 then 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 jealously 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 100000 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-folder 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 court-ordered 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

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).

"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
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Colorado Department of Public Safety
Zoe Henry, Research Coordinator

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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 justice system

   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 medial 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:
   For the purposes of scoring this instrument:

   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 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.

   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 form 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 of 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

		Yes
1.	**Prior domestic violence conviction . . . . . Critical Risk Factor--Level C**	☐
	Any of the following are Significant Risk Factor –- Level B (minimum)	Yes
2.	Violation of an order of protection (documented violation)	☐
3.	Past or present civil domestic violence related protection orders against offender	☐
4.	Prior arrests for domestic violence.	☐
5.	Prior domestic violence incidents not reported to criminal justice system. .	☐
	Information Sources: _____ Domain A—Criteria Met	☐
	Identify Level B or Level C _____	

B. Drug or alcohol abuse

	Any of the following are Significant Risk Factor—Level B (minimum)	Yes	Yes
1.	Substance abuse/dependence within the past 12 months.	☐	
2.	History of substance abuse treatment within the past 12 months or 2 or more prior drug or alcohol treatment episodes during lifetime.	☐	
3.	Offender uses illegal drugs or illegal use of drugs.	☐	
	Information Sources: _____ Domain B—Criteria Met		☐
	Level B _____		

C. Mental health issue

	Any of the following are Significant Risk Factor—Level B (minimum)	Yes	Yes
1.	Existing Axis I or II diagnosis (excluding V codes)	☐	
2.	Personality disorder with anger, impulsivity, or behavioral instability.	☐	
3.	Severe psychopathology.	☐	
4.	Recent psychotic and/or manic symptoms.	☐	
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.	☐	
	Information Sources: _____ Domain C—Criteria Met		☐

Level B _____

D. Suicidal/homicidal

Yes

1. **Serious homicidal or suicidal ideation/intent within the past year. . . . . Critical Risk Factor--Level C** ☐

Yes

2. Ideation within the past 12 months . . . . . ☐
3. Credible threats of death within the past 12 months. . . . . ☐
4. Victim reports offender has made threats of harming/killing her (female victims in heterosexual relationships) . . . . . ☐

Information Sources: _____ Domain D—Criteria Met . . . . . ☐

Level C _____

E. Use and/or threatened use of weapons in current or past offense or access to firearms.

Yes

1. **Gun in the home in violation of a civil or criminal court order . . . . . Critical Risk Factor--Level C** ☐
2. **Use and/or threatened use of weapons in current or past offense . . . . . Critical Risk Factor--Level C** ☐

Yes

3. Access to firearms . . . . . ☐

Information Sources: _____ Domain E—Criteria Met . . . . . ☐

Level C _____

F. Criminal history-nondomestic violence (both reported and unreported to criminal justice system). This domain applies only to adult criminal history.

Yes

1. **Offender was on community supervision at the time of the offense . . . . Critical Risk Factor--Level C** ☐
2. **Offender has a prior arrest for assault, harassment, or menacing. If there have been two or more arrests, it is a . . . . . Significant Risk Factor--Level B (minimum)** ☐

Yes

3. Prior nondomestic violence convictions . . . . . ☐
4. Past violations of conditional release or community supervision . . . . . ☐
5. Past assault of strangers, or acquaintances . . . . . ☐
6. Animal cruelty/abuse . . . . . ☐

Information Sources: _____ Domain F—Criteria Met . . . . . ☐

Identify Level B or Level C _____

G. Obsession with the victim

Yes

Yes

1. Stalking or monitoring	. . . . . ☐	
2. Obsessive jealousy with the potential for violence, violently and constantly jealous, morbid jealousy	. . . . . ☐	
Information Sources: _____	Domain G—Criteria Met	☐

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)

	Yes
1. Victim perception of safety/victim concerned for safety	☐
2. Victim (female victim in heterosexual relationship) believes offender is capable of killing her.	☐
3. Offender controls most of victim's daily activities	☐
4. Offender tried to "choke" victim.	☐
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.	☐

Information Sources: _____ Domain H—Criteria Met ☐

I. Violence and/or threatened violence toward family members, including child abuse (does not include intimate partners)

	Yes
1. Current or past social services case(s).	☐
2. Past assault of family members	☐
3. Children were present during the offense.	☐

Information Sources: _____ Domain I—Criteria Met ☐

J. Attitudes that support or condone spousal assault

	Yes
1. Explicitly endorses attitudes that support or condone intimate partner assault.	☐
2. Appears to implicitly endorse attitudes that support or condone intimate partner assault.	☐

Information Sources: _____ Domain J—Criteria Met ☐

K. Prior completed or noncompleted domestic violence treatment Yes

Information Sources: _____ Domain K—Criteria Met	☐

L. Victim separated from offender within the previous six months.

Yes

Information Sources: _____ Domain L—Criteria Met . . . . . ☐

M. Unemployed

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.

Yes

Information Sources: _____ Domain M—Criteria Met . . . . . ☐

N. Involvement with people who have pro-criminal influence

Yes

Yes

1. Some criminal acquaintances. . . . . ☐
   AND
2. Some criminal friends. . . . . ☐

Information Sources: _____ Domain N—Both Criteria Met . . . . ☐

Risk Criteria	Met
A	☐
B	☐
C	☐
D	☐
E	☐
F	☐
G	☐
H	☐
I	☐
J	☐
K	☐
L	☐
M	☐
N	☐
Total Score	____

	Significant/Critical Risk Criteria	Met
----------→	Level B or C? _____	☐
----------→	Level B	☐
----------→	Level B	☐
----------→	Level C? _____	☐
----------→	Level C? _____	☐
----------→	Level B or C? _____	☐

Level A = 0 - 1 risk factors met

Level B = 2 - 4 risk factors met

Level C = 5 or more risk factors met

Level Recommended			Level Placed		
A	**B**	**C**	**A**	**B**	**C**
☐	☐	☐	☐	☐	☐

Comments: _____

_____

_____

_____

_____

_____

Override Reasons: _____

_____

_____

_____

_____

_____

Information Source Codes

1. Offender self-report
2. Law Enforcement Report (Police Reports)
3. Criminal History
4. Mental Health Evaluation/Assessment
5. Substance Abuse Evaluation/ Assessment/Screen
6. Child Protection or Social Services records
7. Public Victim Report/Victim Impact Statement
8. Prison Record
9. Pre-Sentence Report
10. Probation Information Report

11. Other _____

_____

Document or Verify Consensus of MTT

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 that 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 approved *Standards for Treatment for Court Ordered Domestic Violence Offenders* 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 *Standards for Court Ordered Domestic Violence Offender Treatment.* PLEASE NOTE: Promoting healthy sexual relationships can be added to and explored along with any of these competencies at a minimum.

5.08 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

D. Offender development of empathy
   1. Recognizes and verbalizes the effect of one's actions on one's partner/victim

E. 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.

F. Offender identifies and progressively reduces pattern of power and control behaviors, beliefs, and attitudes of entitlement.
   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.

G. Offender Accountability
   1. Recognizes and eliminates all minimizations of abusive behavior.

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
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.

K. Offender understanding, identification, and management of one's personal pattern of violence

5. Acknowledges past/present violent/controlling/abusive behavior

M. 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

P. Offender eliminates all forms of violence and abuse

R. 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)

5.08 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,

[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

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
g. Men's physical and psychological partner directed aggression[4]

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 Insults[5]
   b. Sexual Coercion in Intimate Relationships (SCIRS)[6]
   c. National Intimate Partner and Sexual Violence Survey (NIPSVS) 2010[7]
   d. Sexual Coercion Questionnaire[8]
   (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]

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[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

[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.

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.

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 Massachusetts[10]

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

[10] Rothman, 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

d. CCADV website: http://ccadv.org/
e. National Judicial Education Program web course: Intimate Partner Sexual Abuse: 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.gob

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 Statues:** 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 Statues:** 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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victim safety 5.01(II), 5.06(V), 5.08(IV)

violations of standards 11.16