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Colorado Domestic Violence Offender Management Board
New Directions in Offender Treatment 2016

Who is with us today?

A. Advocacy
B. Batterer Intervention Programs
C. Probation
D. Other (please chat!)
Overview

- Colorado Laws
- DVOMB (Colorado Domestic Violence Offender Management Board)
- Why we revised our treatment standards
- How we revised standards
- Criminology research and DV research
- DVOMB philosophy

Overview (cont.)

- Basic Components of new offender treatment model
  - Offender evaluation
  - DVRNA (CO risk assessment)
  - Levels of treatment
  - Offender competencies
  - Multi-disciplinary treatment team
  - Victim Advocacy
  - Discharge criteria
- Challenges
- DVOMB Studies

COLORADO LAWS
Colorado Laws
Domestic Violence
- Arrest
- Sentencing
- DVOMB
- Use of DVOMB providers
- Therapist Regulation

Statutory Authority
**DVOMB**
- Create board, definitions
- Create standards for treatment and evaluation prioritizing victim safety
- Approve providers and state list
- Research effectiveness

*Other statutes* link to DVOMB authority
- Sentencing statute
- Probation and judicial are required to use DVOMB providers
- DORA state grievance boards

DVOMB Membership
- 19 member multi-disciplinary board
- Seven appointing authorities
  - Department of Corrections
  - Department of Human Services
  - Department of Regulatory Agencies appoints 5 mental health professionals/treatment providers
  - Department of Public Safety appoints 3 victim services representatives, law enforcement, criminal defense attorney
  - Chief Justice appoints judge and probation
  - Colorado District Attorneys Council
  - Colorado State Public Defender
History of DV Treatment in Colorado

- Until 2000 local judicial district boards
- Treatment was implemented inconsistently across the state
- Minimum 36 weeks of treatment was the standard for 15+ years
- In 2000 state board created (DVOMB)

Answer Yes or No

- Are your state BIPs a set number of weeks of treatment, such as 24, 36 or 52 weeks?

Why Colorado revised offender treatment model

- 36 weeks of treatment cannot be applicable to all offenders
  - Does everyone need cognitive behavioral?
  - Do some need education only?
  - Does everyone have same risk?
- Determining appropriate treatment by number of weeks is ineffective
- Offender evaluations inconsistent
- Evaluation and treatment were not highly focused on risk assessment and risk management
- Certain areas of Colorado began circumventing the state standards
How Colorado Revised Offender Treatment

- Created multi-disciplinary committee
- Reviewed research and literature
- Including research related to general criminal population, not just DV
- Other treatment model like this? started from ground up

Research and Literature Review

Dr. Edward Gondolf

- Treatment is effective (30-48 month follow up study)
- Need to improve identification of higher risk offenders
- May need more intensive treatment upfront
- Cognitive behavioral is effective for most men
- Coordinated community response (CCR)
- Victim perception of risk is highly predictive
Jacquelyn C. Campbell

Femicide study 2001 – Risk Factors
- 11 cities, femicide victims n=220, control group of abused women n=343
- 67%-80% of intimate partner homicides involve physical abuse of the female by the male before the murder.
- The strongest sociodemographic risk factor for femicide was the abuser’s lack of employment.
- Both the abuser’s access to a firearm and abuser’s use of illicit drugs were strongly associated with femicide.
- Increase in severity and frequency of abuse over time increases the likelihood of femicide.

Alex Piquero et al

- Meta-analysis
- Criminally, DV offenders are not homogenous group
- Very few specialize in DV offenses
Alex R. Piquero, Robert Brame, Jeffrey Fagan, Terrie E. Moffitt
Assessing the Offending Activity of Criminal Domestic Violence Suspects: Offense Specialization, Escalation, and De-Escalation Evidence from the Spouse Assault Replication Program 2005

- Arrest data from the Colorado Springs study:
  - 1,525 unique suspects
  - 624 individuals (40.9% of 1,525) had at least one prior arrest.
  - Among these 624 individuals, 41 = 6.6% could be characterized as violent specialists
  - Not a homogenous group

Patterns of Violence Over Time
Piquero, visual created by Cheryl Davis

Answer Yes or No

- Are you familiar with the Risk Needs Responsivity (RNR) model?
Andrews and Bonta

- Criminology research
- R-N-R Principles (Risk, Needs and Responsivity)
- Risk Assessment
  - matching treatment intensity to risk
  - High risk and low risk offenders
  - Treatment dose
- Criminogenic needs
- Responsivity
  - Therapeutic alliance

Hart and Kropp

- Research based risk factors
- SARA

Lundy Bancroft

- Author/trainer
- The Batterer as Parent
- Perpetrator accountability
- Competencies for treatment
Philosophy of Treatment

- Treatment is not a 'cure all'.
- Term “treatment” does NOT mean mental health issue
- It cannot be viewed in isolation.
- Treatment can only be effective if the offender wants change AND the rest of the community including the criminal justice system is a part of containment and management.
- 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 non-violent cognitive-behavioral skills. The degree of personal change ultimately rests with the offender.

Main Components of New DV Treatment Model

- Offender evaluation - focus on risk assessment
  - Recommends initial placement in treatment
  - Offender baseline
- Domestic Violence Risk and Needs Assessment instrument (DVRNA)
- Levels of Treatment
- MTT (multidisciplinary treatment team)
- Offender Core Competencies
- Discharge criteria
- Victim Advocacy

Victim Safety Remains Priority of Treatment
Offender Evaluation

- Goal: Standardized, consistent
- Identifies minimum information to be gathered/reviewed
- Brief overview report required
- Criteria for alternative treatment recommendations

Offender Evaluation Section 4.0

- Goal is to have standardized, consistent offender evaluations statewide
- Identifies minimum information that must be gathered/reviewed/assessed
- Brief overview to supervising agent required, identify offender baseline/risk
- Criteria for alternative treatment recommendations
Minimum information for Offender Evaluation

• Required External Sources of Information
  ◦ police reports, victim impact statements, criminal history, victim input, etc.

• Required Assessment Instruments
  ◦ SARA, substance abuse screen, the DVRNA

• Required Minimum Content of Offender Interview
  ◦ Offender accountability, responsivity factors and criminogenic needs

DVRNA
Domestic Violence Risk and Needs Assessment

Classify offenders by risk
Justify change in level of treatment
Face and content validity
8 of the 14 factors are dynamic
All domains are research based

DVRNA (Domestic Violence Risk and Needs Assessment)

Used to classify offenders and place in appropriate intensity level of treatment
Can also be used to justify change in level of treatment
DVRNA has face validity
8 of the 14 domains are dynamic
Risk factors identified in research (J. Campbell, Gondolf, SARA, DVSI, LSI)
Validation study
Risk factors on DVRNA

- Suicidal/homicidal
- Obsession with the victim
- Current or past use of a weapon
- Victim safety concerns
- Criminal history non DV of offender
  - Prior arrests, DV and non DV related
  - Prior convictions, DV and non DV related
  - Violation of community supervision
- Criminal history DV

DVRNA (cont)

- Drug or alcohol abuse
- Mental Health issues
- Violence towards family members
- Attitudes that support or condone spousal assault
- Prior DV treatment
- Separation from victim within last six months
- Unemployed
- Absence of verifiable pro-social support system

Levels of Treatment
Answer: A, B, C, D

• A: Your BIPs are only educational
• B: Your BIPs are cognitive behavioral based
• C: Your BIPs are a combination of psycho- and cognitive behavior
• D: Other

Levels Of Treatment

- Treatment varies by intensity
  - intensity of contact
  - intensity of content
- Levels of treatment can change during treatment
- **Level A: low intensity (0-1 risk factors on DVRNA)**
  - Contact – once a week
  - Content – mostly psycho-educational
  - Two treatment plan reviews at minimum
  - No concerns from victim regarding safety
  - No pattern of abuse
  - Intended to be for the population with no history of abuse, an unusual incident
  - Therefore small numbers of offenders
  - Can be moved to Level B or Level C

- **Level B: moderate intensity (2-4 risk factors on DVRNA)**
  - Contact – once a week, plus once a month minimum
  - Content – some psycho-educational, cognitive behavioral, therapy
  - Three treatment plan reviews at minimum
  - Some concerns from victim regarding safety
  - Pattern of abuse
  - Intended to be for the majority of offender population
  - Therefore large numbers of offenders
  - Offender cannot be moved to Level A
  - Offender can be moved to Level C
• **Level C**: high intensity (more than 4 risk factors on DVRNA)
  - Contact – twice a week minimum
  - Content – crisis management, highly focused on victim safety, cognitive skills based
  - Additional core competencies required
  - Three treatment plan reviews at minimum
  - Major concerns from victim regarding safety
  - Pattern of abuse, criminal thinking, antisocial or psychopathic features
  - Intended to be for the higher risk, minority of offender population
  - Therefore small numbers of offenders
  - Offender can move to Level B if risk is mitigated and MTT is in consensus.

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**Treatment Plan Reviews**

- Required offender progress assessments
- Defined intervals — every 2-3 months
- Required minimum number depending on level
- Review progress
- Revise treatment plan
- Change level of treatment
- Provide offender with progress assessment

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**Offender Competencies**
Offender Core Competencies

- Skills, concepts, behaviors that offender will have to demonstrate that they understand and are applying.
- Adapted from Lundy Bancroft and Colorado Sex Offender Management Board Standards
- Examples:
  - Commitment to the elimination of abusive behavior
  - Development of empathy
  - Offender accepts full responsibility for the offense and abusive history
  - Identification and progressive reduction of the offender's pattern of power and control behaviors, beliefs, and entitled attitudes.

- Accountability
- Acceptance by the offender that one's behavior has, and should have, consequences.
- Participation and cooperation in treatment
- The ability to define types of violence
- An understanding, identification, and management of one's personal pattern of violence.
- Recognition of financial abuse and management of financial responsibility
- Elimination of all forms of violence and abuse.

TEAM DECISION MAKING
Multi-disciplinary Treatment Team
- Treatment provider, treatment victim advocate and supervising agent for the court, child welfare
- Implementation vary by county/district
- Team consensus is required:
  - Offender initial placement in treatment, changes to level of treatment, and discharge
- Role of the treatment victim advocate

Benefits of MTT
- Greater information sharing
- Synergistic
- Improved offender containment and management
- Widens perspectives of team members
- Creates more balanced view
- Prevents triangulation, offender manipulation
- Victim confidentiality

Who is on team
- Comprised at a minimum of treatment provider, treatment victim advocate and supervising agent for the court

Victim Advocate
Probation
Treatment Provider
Other (DSS, VA, etc.)
Victim Advocacy

- Outreach by victim advocate
- MTT always considers safety of victim
- Victim information protected and confidentiality maintained at all times
- Advocate represents victim dynamics

Victim Advocacy and Safety

- Victim confidentiality
- Advocate works with treatment agency
- Outreach to victim
- Victim driven/empowerment
- MTT protects confidentiality
- Advocate may represent only general victim dynamics and knowledge

How Advocacy Works in Offender Treatment
### Consistency in Victim Safety

- Parameters to promote consistency
  - Victim information protected and confidentiality maintained at all times
  - Offender core competencies must be demonstrated prior to discharge
  - All offenders shall have the minimum number of required treatment plan reviews
  - Prior to the first treatment plan review the provider must have obtained and reviewed offender criminal history and available victim information
  - Level system and risk factor decision tool have rule outs. This means that if an offender meets certain criteria he/she cannot be discharged prior to completing additional competencies and additional treatment plan reviews.
  - Offenders cannot be moved to Level A

### Offender Discharge from Treatment

**Discharge Criteria**

- Length of treatment is determined by offender risk and degree of offender progress in treatment as determined by the MTT
- Three types of discharge
  - Completion
  - Unsuccessful
  - Administrative
- Consensus of MTT that type and timing of discharge is appropriate
Treatment Completion

- (Use of word “successful”)
- Offender risk needs to be mitigated
- Offender competencies have to be met/completed
- No new risk factors or offenses
- Consensus of MTT that discharge is appropriate
- Required treatment plan reviews have been completed.

Implementation Challenges

- Evaluations
- Fees for services
- MTT communication

- Allows for consistent treatment model statewide
- Collaborative process of professionals promotes buy in, especially with probation, victim services, criminal justice system
- As challenges arise, we can still work toward consensus and buy in; exs. MMJ, E-therapy, revising stds, non court ordered tx, interstate compact, rural issues no providers,

- DVOMB members work together to implement and enforce
- Statewide collaboration implementation
- Statewide consistency of evals, treatment, supervision, helps victim services
- Victim advocacy required
- State list of approved providers
- Authority to implement and enforce
- Collaboration with state – grievances/complaints
- Providers can be underpaid and pressured by offenders and probation to charge less—push back on offenders can’t afford to pay for eval and treatment. (Averages: $50/eval, $20/group treatment)
- Inconsistent evaluations
- Victim advocacy unfunded
- MTT challenges—other therapists not participating

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**Colorado RESEARCH**

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**Offenders in Treatment in CO**

- 2004-2006 Study
- 95% provider participation
- N= 5,000+
- 81% male
- 39% age: 25-34
- 28% age: 35-44
- 68% employed at time of offense
- 74% employed at discharge (successful)
- Felony (8%)
- Misdemeanor (92%)
- Harassment majority
Data Collected in Colorado
Preliminary Report on the Findings from the Domestic Violence Offender Management Board
Data Collection Project: An Analysis of Offenders in Court-Ordered Treatment, 2006

- 81% male
- N= 5080

Age of Offender in Treatment
67 percent of offenders in this data set were between the ages of 25 and 44 years of age.

Offense of Record

- Violation of PO (276)
- Criminal Mischief (455)
- Harassment (1667)
- Assault (2222)
DVOMB Studies

2014
Tracking Offenders in Treatment,
◇ N= 1,541
◇ Only offenders in treatment in Colorado
◇ No offender identifying data

RESEARCH QUESTION 1
What is the distribution of offenders into the different levels of treatment at initial placement in treatment and discharge?

RESEARCH QUESTION 2
What is the frequency of successful discharges by treatment level?
RESEARCH QUESTION 3
What is the average length of time in treatment for each discharge outcome for offenders in levels A, B, and C?

Average Length of Treatment by Level (Weeks)

<table>
<thead>
<tr>
<th>Level</th>
<th>Successful</th>
<th>Unsuccessful</th>
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<tbody>
<tr>
<td>Level C</td>
<td>13.8</td>
<td>37.3</td>
</tr>
<tr>
<td>Level B</td>
<td>16.2</td>
<td>24.4</td>
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<tr>
<td>Level A</td>
<td>16.5</td>
<td>24.8</td>
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</tbody>
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DVOMB Studies (cont.)

2016
DVROMA Validation – in process

2015
Research and literature review
Youth who have committed Domestic Violence, 2015

2016 Current JAG Project
with University of Colorado Denver, University of Baltimore

- Task 1: Creation of a treatment provider advisory council.
- Task 2: Treatment provider sampling and selection.
- Task 3: Treatment provider data collection through structured length of treatment and treatment outcomes.
- Task 4: Collection of offender treatment data, including treatment files, discharge data and recidivism data.
- Task 5: Qualitative content analysis of interview data and treatment files.
- Task 6: Analysis of the relationship between treatment outcomes and recidivism.
- Task 7: Provide briefing on findings and implications.
QUESTIONS?

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