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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 differ-ential 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 37)

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 Multidisciplinary Treatment Team (MTT)

I. **MTT Membership**: The MTT consists of Approved Provider, responsible criminal justice agency, and treatment victim advocate at a minimum.

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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. 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 (*Standard* 7.04 g). Therefore, the treatment victim advocate will not be expected to violate victim confidentiality. The treatment victim advocate provides perspectives and insights regarding victim issues in general, not a specific victim. (Please note: Some information is not confidential such as homicidal, suicidal ideation/intent, and child abuse)

Discussion Point: Protection of the victim is priority, therefore, if the only information available that would

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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 (*Standard* 3.0). MTT members may choose to justify in writing, utilizing offender competencies and risk markers 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.

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VIII. **Treatment Report**: At a minimum of once a month, the Approved Provider will 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. Offenders 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 members 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.

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

V. **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 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).

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,

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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's statements shall be kept in a file separate from the offender file.
   2. When a victim states that his/her information cannot be revealed, for the purposes of treatment planning, the Approved Provider shall consult with probation and try to ascertain other 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.

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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).
   1. Violation of an order of protection (B-SAFER, 2005, Kropp & Hart 2008, DVSI, 1998)
   2. Past or present civil domestic violence related protection orders against offender.
   3. Prior arrests for domestic violence (Ventura & Davis, 2004)
   4. Prior domestic violence incidents not reported to criminal justice system (Cattaneo & Goodman, 2003).

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5. Prior domestic violence conviction (ODARA, 2005) Critical Risk Factor that indicates initial treatment placement in LEVEL C

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 instability (Kropp & Hart, 2008; B-SAFER, 2005)
3. Severe psychopathology (Gondolf, 2007, Hare 1998)
4. Recent psychotic and/or manic symptoms (Kropp & Hart, 2008)
5. Psychological/psychiatric condition currently unmanaged
6. Noncompliance with prescribed medications and mental health treatment
7. Exhibiting symptoms that indicate the need for a mental health evaluation

D. Suicidal/homicidal
1. Ideation within the past 12 months (Kropp & Hart, 2008; B-SAFER, 2005)
2. Credible[4] threats of death within the past 12 months (Kropp & Hart, 2008;)

[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

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3. Victim reports offender has made threats of harming/killing her (female victims in heterosexual relationships [5] (Campbell, 2008)
4. Serious[6] 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)

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)
   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)

4“Credible” as defined in the SARA means that the threats were perceived as credible by the victim.
5 Jacquelyn Campbell’s work cited in this document refers to her work on femicide and only female victims in heterosexual relationships.
6 “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.
[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.

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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)

G. Obsession with the victim:
1. Stalking or monitoring (Campbell, 2003; Block, Campbell, & Tolman 2000)
2. Obsessive jealousy with the potential for violence, violently and constantly jealous, morbid jealousy (Wilson & Daly, 1992, Hilberman & Munson 1978, Campbell, 2003)

H. Safety concerns
(The ultimate goal in reviewing and utilizing information is to protect the victim. Information shall not be used if it compromises victim safety and confidentiality (refer to *Standard* 5.04 II.)
1. Victim perception of safety/victim concerned for safety (Gondolf, 2001;Klein, 2008; Buzawa, et al., 2000; ODARA, 2005; Heckert & Gondolf, 2004)
2. Victim (female victim in heterosexual relationship) believes offender is capable of killing her (Campbell, 1995)
3. Offender controls most of victim's daily activities (Campbell, 1995; Block, Campbell, & Tolman 2000; Tjaden & Thoennes, 2000)
4. Offender tried to "choke"[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)

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

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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)

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)

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. Absence of verifiable pro-social support system
   1. Some criminal friends (LSI, 2005)
   2. Friends, family and/or acquaintances who are criminally oriented

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 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,

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[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.

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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 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)

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B. Aftercare Plan
The offender's Aftercare Plan is a 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 as defined in the Glossary during the time in treatment
2. To meet financial responsibilities for evaluation and treatment
3. To agree not to abuse 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 must 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 responsible 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 meet court ordered family obligations
7. To not to 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.
8. To not to participate in *any* couples 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:

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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. (Reference 6.0 Offender Confidentiality)
   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 scale fee. (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. (*Standard* 7.0) The referring agency may request a modification of the notification criteria.

D. Violations of Offender Contract

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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**: 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 (Bonta and Andrews). 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 intake evaluation has been completed and approved by the MTT. While some offenders may remain in the same level throughout treatment, there is also the ability to move offenders to a different level of treatment as needed. This is based on new information such as change in risk factors, mitigation of risk, continuing abuse, or denial.

A. Only offenders in Level C may be considered for a decrease in treatment level and then only to Level B.

B. No offenders in Level B or C are eligible for a decrease in treatment to Level A.

C. Decreasing an offender's level of intensity of treatment shall only occur at scheduled Treatment Plan Review intervals and shall be approved by consensus of the MTT. This change in treatment level shall include written justification placed in the offender's file describing the need for change in treatment.

D. Increasing an offender's level of treatment to a higher intensity of treatment may occur at any time and shall be approved by consensus of the MTT. This change in treatment level shall include

[1] Refer to chart on page 1 entitled "Overview of Offender Treatment Model"

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written justification placed in the offender's file describing the need for change in treatment.

III. **If Critical 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 (See 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.

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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)

D. Offenders in all levels of treatment may be together for some educational components of treatment.

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 (*Standard* 5.09).

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)**

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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 DVRNA and the pre or post-sentence intake evaluation (*Standard* 4.0), 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

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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 (*Standard* 4.0) 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 (or demonstrated equivalent experience and training). 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

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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 (*Standard* 4.0) 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 clinical contacts per week to address core competencies and an additional treatment session such as cognitive skills group, substance abuse, or mental health issues group.
   a. A clinical contact involves therapeutic intervention specifically related to the offender's criminogenic needs and risk factors. Therefore the two contacts cannot be on the same day.
   b. The intent of this level of treatment is to disrupt patterns of abuse.
   c. Face to face contact is required so the Approved Provider can assess the offender's attention level responsiveness, appearance, possible substance abuse, and mental health status. This contact will also assess and promote victim safety.

2. Substance Abuse Treatment: Violence cannot be successfully treated without treating substance abuse problems. All offenders evaluated as needing substance abuse treatment shall complete such treatment. Such treatment shall be provided by a CAC II or

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higher (or demonstrated equivalent experience and training). If the Approved Provider does not provide a substance abuse treatment program, the Approved Provider shall conduct shared case supervision (treatment planning) with the substance abuse Approved Provider 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.

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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/markers.

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*

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to contact on a case by case basis throughout treatment as well as prior to discharge.

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

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

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

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

A. Purpose of this Treatment Plan Review is to measure offender progress and motivation, and to determine whether there are additional clinical needs necessary to achieve treatment goals and to determine whether additional Treatment Plan Reviews are needed.

B. The MTT shall determine whether additional treatment plan reviews are needed based on the offender's progress toward meeting treatment goals and offender competencies. If the offender has not met all treatment goals nor met all discharge criteria, then additional Treatment Plan Reviews shall be scheduled. The offender shall be informed of the goals for the next Treatment Plan Review and the goals shall be identified in writing.

C. Treatment Discharge planning may begin for Level A offenders at this Treatment Plan Review only if offenders can complete all required Treatment Completion Discharge criteria prior to the next Treatment Plan Review (Standard 5.09 I). Once the discharge criteria have been met, the MTT may determine the discharge date.

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Treatment Discharge is based on offender mastery 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 is based on offender mastery of all required competencies, completion of treatment goals, mitigation of risk, and other factors as identified in the Treatment Plan. (*Standard* 5.09 I Treatment Discharge) Treatment discharge planning may begin for Level B and C offenders at this Treatment Plan Review only if all treatment goals and Treatment Completion Discharge criteria have been met or can be met prior to the next Treatment Plan Review. 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 Section 5.07, V B). Completion of a Treatment Plan Review does

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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 markers, 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. (Must 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[13]:** (Bancroft & Silverman, 2002)

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

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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 (*Standard* 7.0 – Victim Advocacy Coordination).

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

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

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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 IVA 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 (Tolman & Edleson, 1992).
   3. Demonstrate behaviors, attitudes and beliefs congruent with equality and respect in personal relationships.

G. Offender Accountability (Refer to Appendix A, Offender Evaluation)
   Offender accountability is defined as accepting responsibility for one's abusive behaviors, including accepting the consequences of

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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. (see Appendix regarding Offender Evaluation)

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)

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

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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.

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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.

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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, criminal justice referring agent and the treatment victim advocate shall be apprised of this information and the Treatment Plan shall be adjusted accordingly.

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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

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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 – MTT.

> *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.*

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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 can 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

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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 (*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.

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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 (*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.

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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 (*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 criminal justice agency's written approval. The receiving Approved Provider, the previous Approved Provider, and the MTT shall do case coordination, including discussion of any additional treatment that may be required. The final recommendation for treatment will 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 obligated to provide a copy of the discharge summary immediately upon receipt of the release.

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The Approved Provider shall create a Discharge Summary to be provided to probation and/or the court. This summary shall document findings from *Standard* 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 (*Standard* 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 Therapy

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I. Couple's counseling is not a component of domestic violence treatment. The offender is the offender 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 therapy while in offender treatment. This includes any joint counseling that involves the offender and the victim.

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

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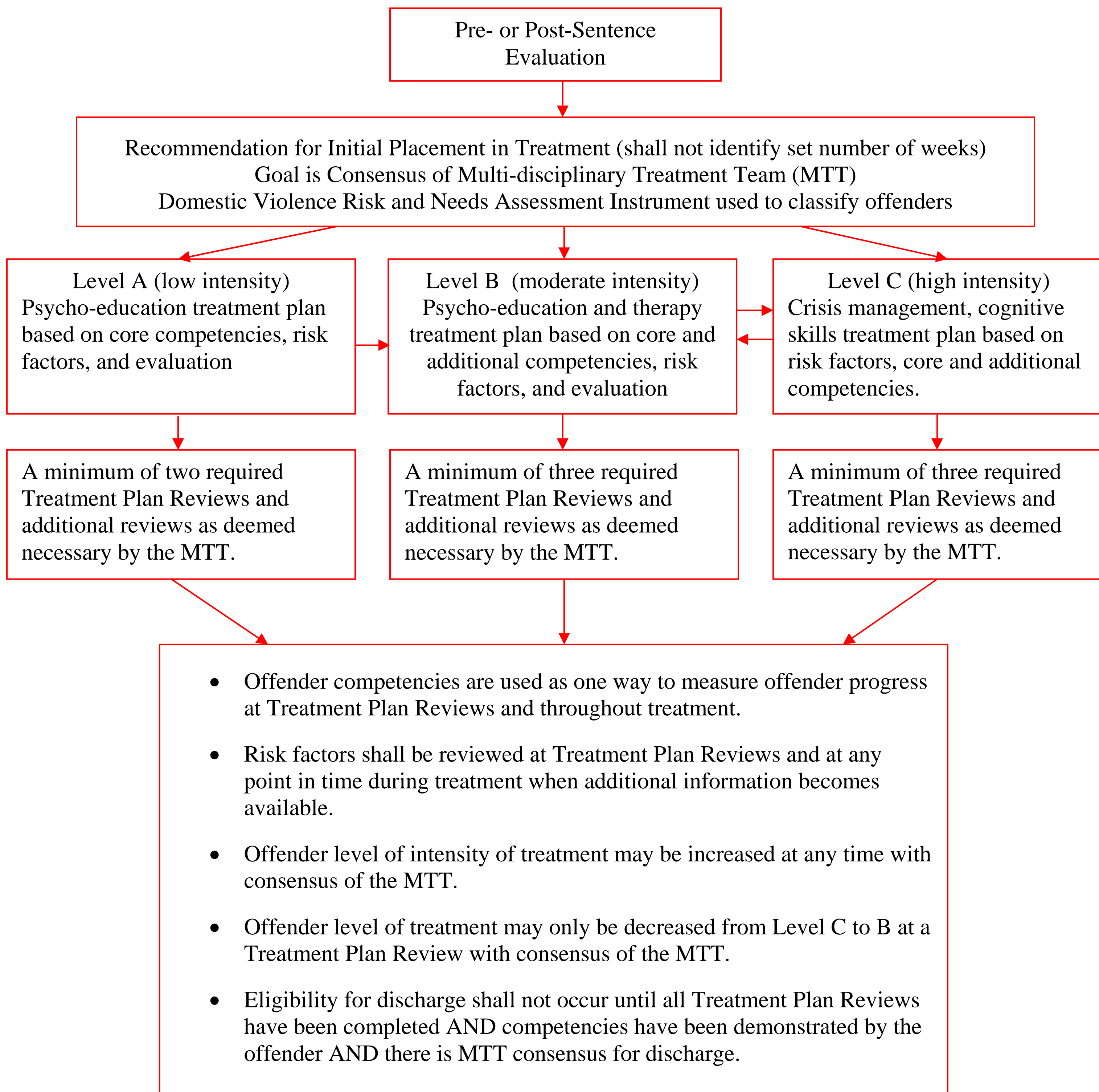
OVERVIEW CHART OF 5.0 OFFENDER TREATMENT



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6.0 Offender Confidentiality

For information regarding victim confidentiality refer to *Standard* 7.0

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 probation victim services officers) and all members of the MTT and, if applicable, to the 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.

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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, Section 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.

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ANNOTATED DVRNA

(Domestic Violence Risk and Needs Assessment)

Prepared by Domestic Violence Unit
Division of Criminal Justice
Colorado Department of Public Safety

October 14, 2009

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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.

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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.

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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.

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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.

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Domain A. Prior Domestic Violence Related Incidents:

- Violation of an order of protection (B-SAFER, 2005; Kropp & Hart, 2008; DVSI, 1998)
- Past or present civil domestic violence related protection orders against offender.
- Prior arrests for domestic violence (Ventura & Davis, 2004)
- Prior domestic violence incidents not reported to criminal justice system (Cattaneo & Goodman, 2003).
- Prior domestic violence conviction (ODARA, 2005)

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:

- 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)
- 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)
- Offender uses illicit drugs or illegal use of drugs (Campbell, 1995)

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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

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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:

- Existing Axis I or II diagnosis
- Personality disorder with anger, impulsivity, or behavioral instability (Kropp & Hart, 2008; B-SAFER, 2005)
- Severe psychopathology (Gondolf, 2007; Huss & Langhinrichsen-Rohling, 2006))
- Recent psychotic and/or manic symptoms (Kropp & Hart, 2008)
- Psychological/psychiatric condition currently unmanaged
- Noncompliance with prescribed medications and mental health treatment
- 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.

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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:

- Ideation within the past 12 months (Kropp & Hart, 2008; B-SAFER, 2005).
- Credible threats of death within the past 12 months (Kropp & Hart, 2008; Campbell, 2008)
- Victim reports offender has made threats of harm/killing her (female victims in heterosexual relationships [14] (Campbell, 2008)
- Serious homicidal or suicidal ideation/intent within the past year (Kropp & Hart, 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).

Domain E. Use and/or Threatened Use of Weapons in Current or Past Offense or Access to Firearms:

- Gun in the home in violation of a civil or criminal court order (Vigdor & Mercy, 2006)

[14] Jacquelyn Campbell's work in this document refers to her work on femicide and only female victims in heterosexual relationships.

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- Use and/or threatened use of weapons in current or past offense (Kropp & Hart, 2008; Azrael & Hemenway, 2000, Hart, 1990)
- Access to firearms (Langley, 2008; Paulozzi et al. 2001; Mitchell & Carbon, 2002; 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

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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):

- Offender was on community supervision at the time of the offense (DVSI, 1998)
- Offender has a prior arrest for assault, harassment, or menacing (DVSI, 1998; Buzawa, et al., 2000; Ventura & Davis, 2004).
- Prior nondomestic violence convictions (DVSI, 1998; Klein, 2008; ODARA, 2005; Ventura & Davis, 2004)
- Past violation(s) of conditional release or community supervision (bail, probation -Kropp & Hart, 2008; B-SAFER, 2005; ODARA, 2005).
- Past assault of family members, strangers, or acquaintances (Kropp & Hart, 2008; Weisz, et al., 2000; B-SAFER, 2005)
- 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.

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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,

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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).

<u>Animal Cruelty</u>

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 women and 63% of children entering shelters discussed incidents of pet abuse in the family (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

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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:

- Stalking or monitoring (Campbell, 1995; Block, Campbell, & Tolman (2000)
- 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).

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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).

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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):

- Victim perception of safety/victim concerned for safety (Gondolf, 2001;Klein, 2008; Buzawa, et al., 2000; ODARA, 2005; Heckert & Gondolf, 2004)
- Victim (female victim in heterosexual relationship) believes offender is capable of killing her (Campbell, 1995)
- Offender controls most of victim's daily activities (Campbell, 1995; Block, Campbell, & Tolman 2000; Tjaden & Thoennes, 2000)
- Offender tried to "choke" victim (Campbell, 2008)
- Physical violence is increasing in severity (Kropp & Hart, 2008; B-SAFER, 2005)
- Victim forced to have sex when not wanted (Campbell, 1995)
- Victim was pregnant at the time of the offense and offender knew this (Martin et al., 2001; ODARA, 2005)
- Victim is pregnant and offender has previously abused her during pregnancy (Gazmararian, 1996; Martin et al., 2001)

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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).

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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.

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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).

<u>Victim's Perception of Safety</u>

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):

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- Current or past social services case
- Past assault of family members (Kropp & Hart, 2008)
- 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

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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:

- Explicitly endorses attitudes that support or condone intimate partner assault.
- Appears to implicitly endorse attitudes that support or condone intimate partner assault.

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

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(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).

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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).

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Domain N: Absence of Verifiable Pro-social Support System.

- Some criminal friends (Andrews & Bonta, 2005)
- Friends, family and/or acquaintances who are criminally oriented

"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 (Andrews & Bonta, 2005).

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