DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD

STANDARDS FOR TREATMENT WITH COURT ORDERED DOMESTIC VIOLENCE OFFENDERS

A PROCESS EVALUATION

A Report of Findings per 16-11.8-103(4)(IV) C.R.S.

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Introduction

Pursuant to 16-11.8-103(4)(IV), C.R.S.[1], this report presents findings on the degree to which Standards for the treatment of court ordered domestic violence offenders (hereafter *Standards*) have been implemented in Colorado. This report represents the first step in assessing the effectiveness of the *Standards* for court ordered domestic violence offenders by evaluating the extent to which they have been implemented[2].

Background

The Colorado Domestic Violence Offender Management Board (DVOMB) was created by the General Assembly in the Colorado Department of Public Safety in July 2000 pursuant to 16-11.8-103, C.R.S. The legislative declaration in the Board's enabling statute states that the consistent and comprehensive evaluation, treatment, and continued monitoring of domestic violence offenders at each stage of the criminal justice system is necessary in order to lessen the likelihood of re-offense, to work toward the elimination of recidivism, and to enhance the protection of current and potential victims (16-11.8-101 C.R.S.). The DVOMB was charged with the promulgation of *Standards* for the evaluation, treatment, and monitoring of convicted domestic violence offenders and the establishment of an application and review process to approve DV Treatment Providers (hereafter providers).

The *Standards* were revised in 2010 to more closely adhere to the principles of risk, need, and responsivity (RNR) (Andrews & Bonta 2010; Andrews & Dowden, 2006; Latessa & Lowencamp, 2006; Radatz & Wright, 2015). The RNR principles state the following:

Risk Services provided to offenders should be proportionate to the offenders' relative level of static and dynamic risk (i.e., low, moderate, or high risk) based upon accurate and valid research-supported risk assessment instruments;

[1] C.R.S. - 16-11.8-103(4)(IV): Research and analyze the effectiveness of the treatment evaluation and treatment procedures and programs developed pursuant to this article. The board shall also develop and prescribe a system for implementation of the guidelines and standards developed pursuant to subparagraphs (I) and (II) of this paragraph (a) and for tracking offenders who have been evaluated and treated pursuant to this article. In addition, the board shall develop a system for monitoring offender behaviors and offenders adherence to prescribed behavioral changes. The results of such tracking and behavioral monitoring shall be part of any analysis made pursuant to this subparagraph (IV).

[2] In order to properly study program effectiveness, evaluation research first requires that a process evaluation (or implementation evaluation) be conducted to determine if a particular program is implemented as it is designed in theory (Love, 2004). The second step involves an evaluation of outcomes which assesses the effectiveness of a particular program assuming that it has been implemented fully.

Need	Interventions are most effective if services target criminogenic needs (both social and psychological factors) that have been empirically associated with recidivism; and
Responsivity	Effective service delivery of treatment and supervision requires individualization that matches the offender's culture, learning style, and abilities, among other factors.

This change in the *Standards* eliminated the previous minimum length of 36 weeks for all offenders and instituted a differential treatment model with three different risk categories. The purpose of the Domestic Violence Risk and Needs Assessment (DVRNA) instrument is for offender risk classification and for matching offender risk with the intensity of treatment (See Appendix A for more information on the DVRNA).[3] The DVRNA is a research-informed instrument developed by the DVOMB and is used for assessing the factors that should be considered when working with adult domestic violence offenders (18 years and older) in treatment. These risk factors identified from the literature comprise 14 domains in the DVRNA into a single measure that can predict an offender's likelihood (probability) of ongoing or repeat violence. Based on the score, an offender may be placed into one of three categories of intensity of treatment: low risk (Level A), moderate risk (Level B), or high risk (Level C). Risk levels may increase or decrease for some clients between placement and discharge based on their progress in treatment and dynamic risk factors. See Appendix A for more information on the DVRNA.

The domestic violence (or batterer intervention) literature is still developing. Scholars and policy-makers alike are increasingly searching for correctional strategies and interventions intended to promote the successful rehabilitation of criminal populations in order to reduce recidivism (Braga & Weisburd, 2013). Despite developments in the domestic violence literature, more research is required to study the degree to which Batterer Intervention Programs (BIPs) adhere to State *Standards* (Boal & Mankowski, 2014a; Price & Rosenbaum, 2009) and if so, how effective these *Standards* are at reducing recidivism (Corvo, Dutton, & Chen, 2008; Holtzworth-Munroe, 2001).

The purpose of this process evaluation is three-fold: (1) determine if the *Standards* have been implemented to a sufficient degree to warrant an outcome evaluation; (2) identify specific areas of the *Standards* that have not reached substantial implementation; and (3) understand current gaps and barriers to implementing the *Standards*.

[3] The DVRNA is a risk assessment instrument developed by the Division of Criminal Justice for use with adults 18 years and older who have been arrested and are in the criminal justice system for a domestic violence offense. The DVRNA was designed to identify risk factors that should be considered when working with domestic violence offenders in treatment by determining an appropriate level of treatment intensity. The DVRNA consolidates numerous risk factors that have been identified through empirical research as increasing the risk of violence or escalating in seriousness into a single measure to determining the likelihood (probability) of ongoing or repeat violence. It is intended to be completed once all the evaluation data has been gathered.

Methodology

This report presents findings from two separate process evaluation studies conducted by the DVOMB to assess implementation.

1. Tracking Offenders in Treatment Study – A total of 60 providers from approximately 45 programs across the state collected data regarding 1541 offenders who were court ordered to attend DV treatment. The data collection instrument (see Appendix B) included measures of different stages of treatment and descriptive information regarding an offender's risk level and progression through treatment.

   The research questions evaluated the following:

   (1) How do offenders score on the DVRNA at initial placement and discharge?

   (2) What is the frequency of successful discharges by risk level identified by the DVRNA? Does the risk level on the DVRNA correspond to treatment outcome?

   (3) What is the average length of time in treatment for each DVRNA risk level?

   In total, data were collected on 1561 offenders from June 1, 2011 to November 31, 2012.

2. Provider Implementation Standards Study – 147 Multi-Disciplinary Treatment Team (MTT) members (e.g., treatment providers, treatment victim advocates, and probation officers) participated in an anonymous online survey between September and November of 2014 (see Appendix B for the survey questions). Emails and flyers soliciting MTT member participation in the survey were disseminated to all providers, treatment victim advocates, and probation officers with active DV caseloads. A total of 59 providers, 13 victim advocates, 74 probation officers, and 2 with affiliations participants responded to the survey. On average, providers who participated in the survey had approximately 14 years of experience working in the field of domestic violence while other MTT members had on average 8 years of experience (SD = 6.0). The online survey asked MTT members questions related to the implementation of *Standards*, MTT decision-making, and questions regarding barriers to implementation. Several questions focused on specific *Standards* that were changed in 2010. Other questions focused on gaps and/or barriers to the full implementation of the *Standards*.

Data-entry was conducted by Integrated Document Solutions (IDS) and SPSS (Version 21) software was used for analyzing the data presented in this report.

Key Findings

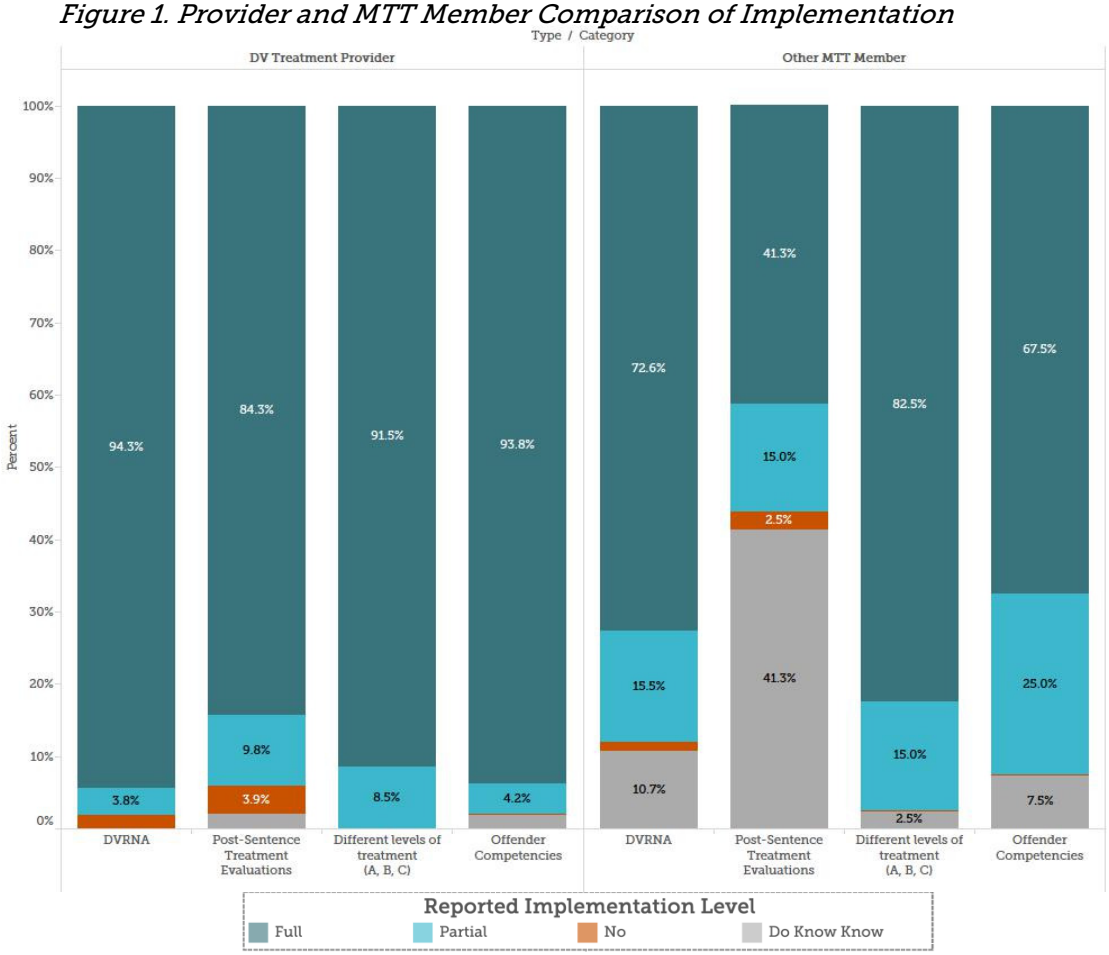
1. *Which Standards have been substantially implemented?*

   - Overall, the majority of providers who participated in the survey (88%, n = 50) reported full implementation of the *Standards*. Providers indicated that full implementation of the DVRNA (Sections 5.04), treatment plan reviews (Section 5.05), differential levels of treatment (Section 5.06), and use of offender competencies (Section 5.08) have been reached.

   - Respondents other than providers (e.g., probation officers and treatment victim advocates) indicated that the *Standards* were fully (50%, n = 42) or partially (43%, n = 36) implemented.

   - Differences emerged between MTT members in their assessment of the degree to which the *Standards* have been implemented. Figure 1 below presents these differences.

Figure 1. Provider and MTT Member Comparison of Implementation



Note: The percentages shown above represent the perceived levels of implementation of professionals working in the field.

2. Pursuant to Section 5.04 of the *Standards*, providers are required to conduct ongoing assessments of offender risk using the Domestic Violence Risk and Needs Assessment (DVRNA). This includes properly administering and interpreting the instrument during the process of treatment. *To what extent are providers using the DVRNA to determine offender risk in their programs?*

   - 98% (n = 56) of providers who responded to the survey indicated that the DVRNA was fully or partially implemented. A majority of responding providers (84%, n = 48) reported that the results of the DVRNA were being incorporated into the offender's treatment plan.

   - Respondents other than providers reported the DVRNA to be fully implemented (73%, n = 61) or partially implemented (16%, n = 13) in their communities.

   - Table 1 presents data regarding the use of the DVRNA by providers.
     - About 12% of those evaluated by the DVRNA are designated as low risk at both placement and discharge.
     - The DVRNA assessed 88% of offenders into Levels B and C, medium and high risk.
     - Approximately 10% of the Level C, high risk offenders were reassigned to Level B, medium risk during treatment.

   Table 1: Number of Offenders by DVRNA Risk Level at Placement and Discharge

Treatment Risk Levels	Placement		Discharge	
	n	%	n	%
Level C – High Risk	705	46%	556	36%
Level B – Medium Risk	649	42%	802	52%
Level A – Low Risk	187	12%	193	12%
Total	1541	100.0%	1551	100.0%

3. Pursuant to Section 5.05 of the *Standards*, providers are required to use the information from the DVRNA at intake for the purposes of developing an individualized treatment plan and recommending placement for treatment. *To what extent are providers individualizing treatment plans and offender contracts in their programs?*

   - In addition to the DVRNA, 98% of responding providers (n = 54) indicated that they also used the Spousal Assault Risk Assessment (SARA) and 40% (n= 22) indicated they use the Domestic Violence Screening Instrument (DVSI). Other domestic violence risk assessment instruments such as the Ontario Domestic Assault Risk Assessment (ODARA) and the Domestic Violence Risk Appraisal Guide (DVRAG) were not reported to be used at all.

4. Pursuant to Section 5.06 of the *Standards*, providers are required to use differential levels of treatment (i.e., Levels A, B, and C) based on the information from the

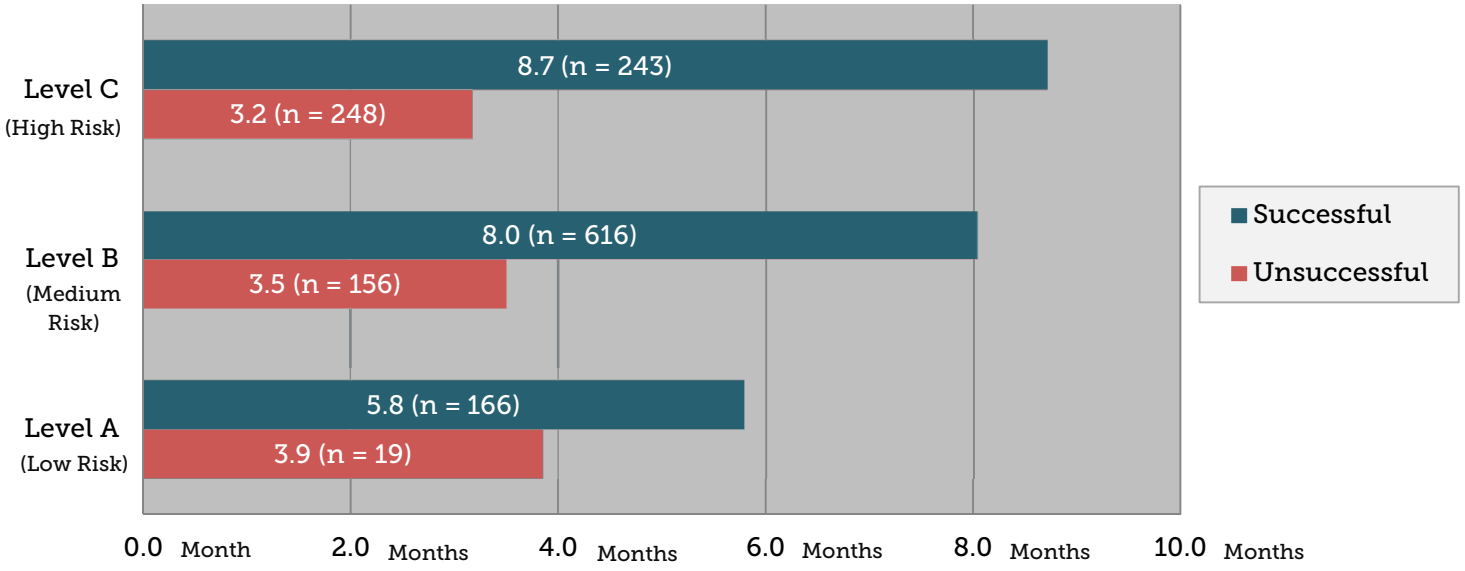
DVRNA at intake to determine the individual risks and needs of the offender. Additionally, differential treatment levels call for varied lengths of treatment based on content and intensity to match the offender's individual needs. *To what extent have providers implemented differential levels of treatment in their programs?*

- 92% of providers responding to the survey indicated that differential levels of treatment were fully implemented (n = 47).

- Respondents other than providers indicated that differential levels of treatment were fully implemented (83%, n = 66) or partially implemented (15%, n = 12) in their communities.

- Figure 1 shows that the length of time in treatment for higher-risk (Level C) offenders was longer. Conversely, lower-risk offenders had shorter lengths of time in treatment. On average, offenders unsuccessfully discharge from treatment at around 3-4 months.

Figure 1. Average Length of Time in Treatment (in months) by DVRNA Risk Level at Discharge



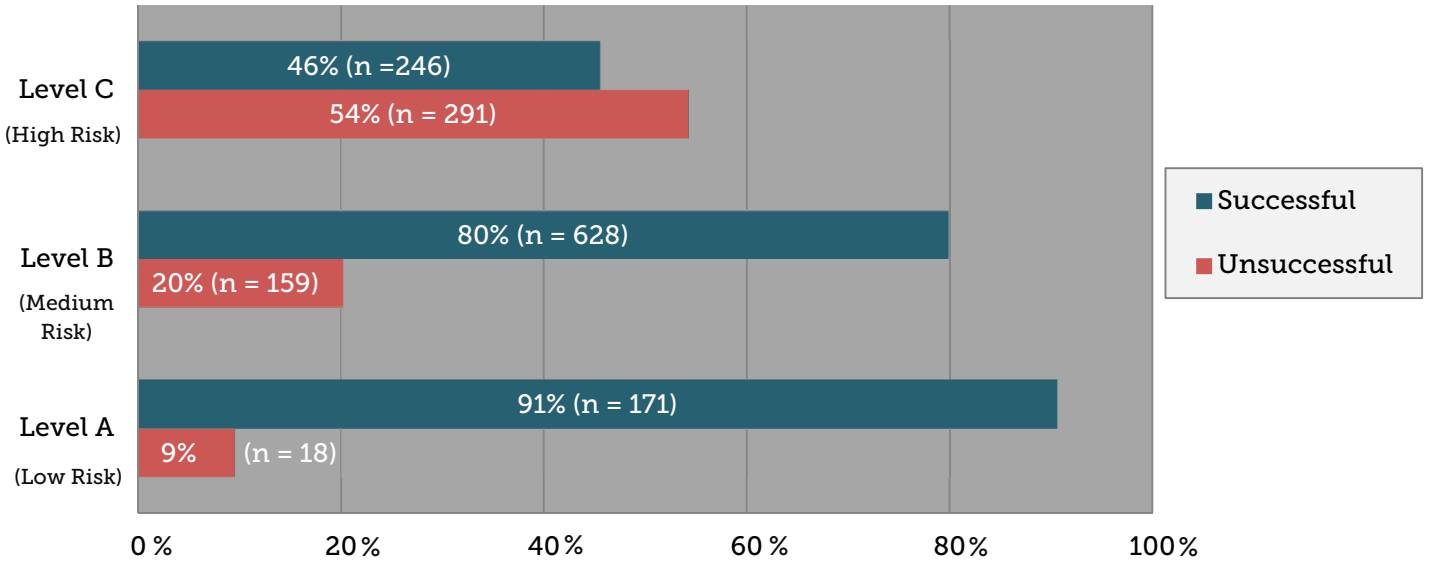
- *Figure 1* indicates that lower risk offenders (Level A) who successfully complete treatment are in treatment on average 5.8 months. Comparatively, medium risk offenders (Level B) are in treatment for 8.0 months and high risk offenders (Level C) for 8.7 months.

- Responding providers indicated that the DVRNA was completed either at in-take (43%, n= 23) or before treatment begins (35%, n = 19). Providers also indicated on the survey that ongoing offender assessments were frequently communicated to other MTT members. Approximately 56% (n = 45) indicated that post-conviction offender assessments were communicated "*Most of the Time*" or "*Always*".

- Data from *Figure 2* suggest the following success rates:

- Approximately 91% of low risk offenders (Level A) successfully completed treatment. These offenders represent only 11% of the sample at discharge.
- Approximately 80% of medium risk offenders (Level B) successfully completed treatment. These offenders represent approximately 42% of the sample at discharge.
- Approximately 46% of high risk offenders (Level C) successfully completed treatment. These offenders represent approximately 16% of the sample at discharge.

Figure 2. Percentage of Successful Treatment Outcomes by DVRNA Risk Level at Discharge



5. According to Section 5.07 for treatment plan review, DV Treatment Providers are required to re-assess an offender's degree of progress in order to make any necessary modifications to the goals, intensity, and modalities of treatment.

    - Responding providers indicated that treatment plan reviews were fully (65%, n = 34) or partially (27%, n = 14) implemented by providers.

    - Respondents other than providers indicated that treatment plan reviews were fully implemented (73%, n = 61) or partially implemented (16%, n = 13) in their communities.

6. Pursuant to Section 5.08 of the *Standards*, providers are required to measure offender readiness and progression in treatment by assessing an offender's competencies. *To what extent have providers implemented offender competencies in their programs?*

    - 94% of responding providers (n = 49) indicated that offender competencies are fully implemented.

- Respondents other than providers indicated that offender competencies were fully implemented (68%, n = 54) or partially implemented (25%, n = 20) in their communities.

7. Pursuant to Section 5.02 of the *Standards*, the MTT consists of the Approved Provider, the referring criminal justice agency, and the Treatment Victim Advocate at a minimum. Other professionals relevant to a particular case may also be a part of the MTT such as human services, child welfare, and child protection services. *Are all members of the MTT active participants as required?*

    - Responding providers reported the implementation of MTTs to be less frequent with 63% reaching full implementation (n = 32) and 29% reaching only partial implementation (n = 15).[4]

    - Approximately 52% of responding providers noted that decisions were made collectively by the MTT. Those who indicated that MTT decision-making was made by one team member (48%) reported that person being the provider. Approximately 74% (n = 61) of respondents other than treatment providers indicated that decisions were primarily made as a group while only 26% reported decisions being made by one member of the team.

    - Survey respondents indicated that MTT members met either monthly (45%, n = 23) or once a quarter (35%, n = 18).

8. Providers are required to conduct evaluations on DV offenders in accordance with Section 4.0 of the *Standards*. *To what extent have providers implemented post-sentence treatment evaluations as required by Section 4.0 in their programs?*

    - Approximately 81% of providers who responded to the survey indicated that Section 4.0 had reached full implementation.[5]

9. Costs for offender services

    - Most jurisdictions use a sliding scale for assessing service fees to domestic violence offenders. Based on the responses from providers, the median price for a group session, an individual session, and an offender evaluation were $25.00, $50.00 and $110.00 respectively. Average cost of services tended to be slightly higher due to some providers charging higher fees than observed in other jurisdictions.

[4] The online questionnaire did not ask other MTT members about the extent to which MTTs had been implemented in their community.

[5] The online questionnaire did not ask other MTT members about the extent to which MTTs had been implemented in their community.

Conclusions

This study combined two separate research projects undertaken by the DVOMB between FY 2011 and 2014. The survey gives evidence that most of the 2010 *Standards* have been implemented as perceived by professionals who work with court ordered DV offenders. A majority of providers reported the *Standards* as being fully implemented with exception of the development of localized MTTs. It should be noted however that MTT professionals other than providers reported mixed levels of implementation on various *Standards*. This result suggests that there may not be broad fidelity to how the *Standards* have been implemented across the state. These variations to the implementation of the *Standards* were observed with offender evaluations, offender competencies, and the DVRNA. Both providers and other MTT members gave descriptions of barriers and challenges to adapting the revised *Standards*, which suggest that certain locales could benefit from greater implementation efforts.

Overall, program level data collected by the DVOMB indicates that the DVRNA is classifying offenders into three risk categories that are linked to program success rates. While only 9.5% of the sample fell into the Level A risk category at discharge, 90.5% of this group successfully completed treatment compared with 79.8% of Level B offenders and 45.5% of Level C offenders at discharge. This finding suggests that the DVRNA risk categories are separating the domestic violence offender population into meaningful risk groups as measured by treatment success rates. It is important to note, however, that conclusions cannot be drawn to explain why Level C offenders are failing at a higher rate. Level C offenders may be discharged unsuccessfully for a multitude of factors which may include a reoffense, a lack of treatment engagement, or the requirements of Level C treatment.

Regarding length of stay in treatment, lower risk offenders who successfully complete treatment are spending, on average, 5.8 months in treatment compared to 8.0 and 8.7 months, respectively, for Level B and Level C offenders. This finding implies that implementation of the DVRNA has led to differential time in treatment; an objective of the DVRNA. Finally, those who were unsuccessfully discharged from treatment spent fewer months in treatment, which would be expected since noncompliance results in early termination from treatment.

Taken together, these findings suggest that (a) the *Standards* pertaining to the DVRNA are implemented as planned, (b) meaningful risk groups are being identified, and (c) differential time in treatment by risk level is underway. Findings from this process evaluation are further detailed and reported upon in Appendix D. For a more comprehensive report evaluating the implementation of the DVOMB *Standards*, please refer to Appendix E.

Limitations. These findings should be interpreted with caution given the limitations that were present in both studies related to sample size and sampling bias. Generalizations regarding the implementation of *Standards* in a particular jurisdiction may not be represented in this data as only 30% of providers participated in the survey.

Individuals who responded to the survey participated on a voluntarily basis and this self-reported information may not be representative of the broader population. For example, a treatment provider who disagrees with a particular *Standard* and experienced a problem in their jurisdiction may be more motivated to participate in the survey than someone who has not experienced an issue with that *Standard*. Further, the response rate for other MTT members (such as probation or victim advocates) could not be accurately determined. All of the data information is self-report data and is based on perception which may not reflect actual practices in the field. The involvement of DVOMB staff in this evaluation may have also influenced providers to change their responses in order to appear compliant with the *Standards*.

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Domestic Violence Risk and Needs Assessment (DVRNA)

Scoring Manual

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2016

Domestic Violence Offender Management Board

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Overview and Administration

Introduction

The Domestic Violence Risk and Needs Assessment (DVRNA) was developed by the Treatment Review Committee (Committee) of the Colorado Domestic Violence Offender Management Board (DVOMB). The Domestic Violence Risk and Needs Assessment (DVRNA) is a risk assessment for adult domestic violence offenders 18 years and older. It is intended to be completed once all the evaluation data has been gathered. It is empirically based and has content and face validity. The DVOMB has obtained funding for a validation study which will begin in October 2010.

This instrument was designed to identify risk factors that should be considered when working with domestic violence offenders in treatment. It is only intended to be used for offenders who have been arrested and are in the criminal justice system for a domestic violence offense. The risk factors that are empirically based on this instrument are predictive for offenders in the criminal justice system. It aids in determining appropriate level of treatment intensity. The DVRNA presents a framework within which to assess the risk of future intimate partner violence for domestic violence offenders in treatment. The DVRNA takes numerous risk factors that have been identified through empirical research as increasing the risk of violence or escalating its seriousness and consolidates these factors into a single measure, thus providing a method of determining the likelihood (probability) of ongoing or repeat violence.

Description

The DVRNA is composed of 14 domains of risk most highly predictive of future violence, which were selected based on an extensive literature review, the clinical experience of the Committee, and the knowledge from the criminal justice system participants. Many items concern an offender's criminal history. A few domains are dynamic in nature, such as current lifestyle stability factors. Risk factors are used as one measure to assist with initial treatment planning including the design of offender competencies, and ongoing treatment plan reviews.

The DVRNA is a risk assessment tool that assigns offenders a total score based on risk for repeated domestic violence. Thus, an offender may be placed into one of three categories of intensity of treatment; low, moderate, or high. For example, any indication of a Significant Risk Factor would require initial treatment placement in the moderate level at a minimum, while an indication of a Critical Risk Factor would require initial treatment placement in the high intensity level.

User Qualifications and Training

The DVRNA was designed to be scored easily by treatment providers in conjunction with the Multi-disciplinary Treatment Team, made up of an Approved Provider, responsible criminal justice agency, and a treatment victim advocate at a minimum. Other professionals relevant to a particular case may also be a part of the MTT such as human services, child welfare, and child protection services. Before using this assessment, it is important to read this manual and the Annotated DVRNA. In addition, users should complete DVOMB training because it is critical to insure rater accuracy and fidelity to the instrument. DVRNA users should have a basic understanding of risk factors related to domestic violence recidivism.

Documentation of Information Sources

When completing the DVRNA for each domain, it is essential to identify the sources utilized to obtain the information. It is preferable to use official records (e.g., mental health, criminal justice reports), credible offender reports and written collateral reports for this documentation. The scoring of the instrument is intended to be transparent and sources of information must be available.

Scoring Instructions
Domain Risk Items

A: Prior Domestic Violence Related Incidents (Any of the following are Significant Risk Factors that indicate initial treatment in Level B except number 1, which is a Critical Risk Factor and indicates treatment in Level C.

This domain applies only to adult criminal history
Do not include offenses committed as a juvenile

1. Prior domestic violence conviction

   Critical Risk Factor that indicates initial treatment placement in Level C.
   Include self reports of convictions
   Includes deferred judgments, guilty pleas
   Include convictions identified in criminal history as reported by probation or criminal justice report

2. **Violation** of an order of protection (documented)

   Include civil or criminal protection orders
   Include past or current orders
   Include temporary protection orders
   Include alcohol violations

3. Past or present civil domestic violence related protection orders against offender

   Does not include criminal protection orders related to the arrest and conviction.
   Do not include automatic orders related to marriage dissolution
   Include temporary and permanent orders

4. Prior arrests for domestic violence

   Include any arrest as an adult that was identified in the arrest as domestic violence

5. Prior domestic violence incidents not reported to criminal justice system

   Include incidents reported by the victim **only** if the victim gives written permission to include this in the scoring of the DVRNA.
   Include offender self report of incidents
   Include any incident commencing after age 18
   Include incidents involving any intimate partner after age 18
   Include incidents reported in writing by collateral contacts or documented interview(s).

Domain B: Drug or Alcohol Abuse (Any of the following are Significant Risk Factors that indicate initial treatment in Level B).

Providers shall follow requirements of Office of Behavioral Health (OBH) for substance abuse assessment: A comprehensive evidence-based or best practices assessment shall be completed as soon as is reasonable, covering the areas required by OBH. All methods and procedures used to assess and evaluate an individual shall be developmentally and age appropriate, culturally responsive, and conducted in the individual's preferred language and/or mode of communication.

Self-report or recent illegal activity involving substance abuse with emphasis on the most recent 12 months can also be used to determine substance abuse.

No problem indicates that there is no alcohol or drug abuse or that alcohol or drugs do not interfere with the offender's functioning.

1. Substance abuse/dependence within the previous 12 months

   Refer to the DSM-IV-TR (or current version) for substance dependence or abuse criteria.

2. History of substance abuse treatment within the previous 12 months, or two or more prior drug or alcohol treatment episodes during adult lifetime.

   Include any court-ordered or voluntary substance abuse treatment or counseling.
   Include offender self-report

3. Offender uses illegal drugs or illegal use of drugs

   Colorado Revised Statutes Section 18-18-404(1) refers to "unlawful use of a controlled substance – using any controlled substance, except when it is dispensed by or under the direction of a person licensed or authorized by law to prescribe, administer, or dispense such controlled substance for bona fide medial needs."

   Illegal use of drugs includes the abuse of prescription medication; abuse of over-the-counter drugs; and or using illegal drugs such as cocaine, heroin, LSD, methamphetamine, etc.

   Tobacco is not included

   You may use offender self-report, police report, criminal justice record, and other witnesses.

   Discussion point:

   Colorado State law, as of June 1, 2015 allows probationers to use medical marijuana unless the court has prohibited it. Therefore, IF an offender has a medical marijuana card as required by the state and IF the court has not prohibited the use of medical marijuana for that particular offender, this medical marijuana use would not be scored in Domain B.

   However, if at any time, the offender abused or is abusing marijuana this would be scored under B.1.

Domain C: Mental Health Issue (Any of the following are Significant Risk Factors that indicate initial treatment placement in Level B at a minimum).

Mental health concerns may be documented from offender self-report, from the diagnosis by a qualified Approved Provider, from medical records, or from a practitioner qualified to identify a disorder. If an Approved Provider is not qualified to assess the mental health of an offender, the offender may need to be referred to a qualified clinician.

1. Existing Axis I or II diagnosis excluding V codes

   The V code section of the DSM-IV-TR deals with other conditions that may be a focus of clinical attention. V codes are not a diagnosis and therefore not scored.
   Do not score a substance abuse/dependence if this has already been scored on Domain B Drug or Alcohol Abuse.

2. Personality disorder with anger, impulsivity, or behavior instability (SARA, 2008)

   This item should be ascertained based on past or current mental health evaluations. If an Approved Provider is not qualified to assess personality disorders, he/she needs to refer to an Approved Provider who is qualified or another qualified clinician.

   Refer to the DSM-IV-TR (or current version)

3. Severe psychopathy

   Psychopathy is a risk for violent behavior. It is a criminal justice construct. It is not defined in the DSM-IV-TR, subsequently you cannot diagnose someone as a psychopath. However, the degree of someone's psychopathy can be used as a risk factor (HARE Psychopathy Checklist Revised-providers must be trained in the use of this tool).

4. Recent psychotic and/or manic symptoms (SARA, 2008)

   "Recent" is defined as the previous 12 months

   Psychotic symptoms may include (a) grossly disorganized or illogical speech, (b) delusions, (c) hallucinations, and (d) grossly bizarre behavior. Manic symptoms include (a) extreme euphoria or irritability, (b) grandiosity, (c) racing thought and pressured speech, and (d) motoric hyperactivity

5. Psychological/psychiatric condition currently unmanaged

   This condition needs to be diagnosed by a medical or health care clinician, by medical records, or by offender self-report.

6. Non-compliance with prescribed medications and mental health treatment

   This information should be obtained from offender self-report or medical records.

7. An offender exhibits symptoms that indicate the need for a mental health evaluation

   These symptoms may include such indicators as possible depression, psychosis, mania, and/or anxiety.

Domain D: Suicidal/homicidal

1. Serious homicidal or suicidal ideation/intent within the past year

   "Serious" as defined in the SARA means that the ideation is experienced as persistent and intrusive or involves high lethality methods; or that the level of intent is moderate to high.

   <u>This is a Critical Risk Factor that indicates initial treatment in Level C.</u>

2. Ideation within the past 12 months

   The term suicidal/homicidal ideation generally refers to thoughts of committing homicide/suicide, including planning how it will be accomplished.

   May be obtained from offender self-report or documented by other clinicians

3. Credible threats of death within the past 12 months

   "Credible" means that the threats were perceived as credible by the victim (SARA, 2008)

4. Victim reports offender has made threats of harming/killing her

   If the information is revealed by a discussion with the victim, protection of the victim is priority. It is imperative that the if the victim signs a release that allows this information to be utilized for scoring the DVRNA, she/he understands the ramifications of signing such a form, possible retaliation from an offender and has received safety planning assistance from the treatment victim advocate.

   When a victim states that his/her information cannot be revealed beyond the Approved Provider, the Approved Provider and the victim advocate, without compromising victim confidentiality, may consult with probation and shall ascertain other potential ways to document or address victim concerns. *For example:* If the victim reports substance abuse by the offender, the Approved Provider may require random urinalysis, thus obtaining information without revealing victim information.

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

This information can be documented utilizing offender self-report, reports from probation, collateral reports, or police reports.

"The use of weapons and threats of death that cause fear in victims are associated with increase risk for future violence." Manual for the Spousal Assault Risk Assessment Guide (SARA). Therefore the offender's use of a weapon toward anyone in the offense is scored.

Use and/or threatened use of weapons include the threat or actual use of any weapon that poses potential realistic physical harm to the victim's life. Potentially deadly weapons may include firearms, knives, and objects used as clubs; or such objects as tools, phones, etc. The object should not be a body part (e.g., hands, feet, mouth).

1. Gun in the home in violation of a civil or criminal court order

   This is a Critical Risk Factor that indicates initial treatment in Level C

2. Use and/or threatened use of weapons in current or past offense

   This is a Critical Risk Factor that indicates initial treatment in Level C

   This information may be obtained from the police report and/or victim statements. If the information is revealed by a discussion with the victim, protection of the victim is priority. It is imperative that the if the victim signs a release that allows this information to be utilized for scoring the DVRNA, she/he understands the ramifications of signing such a form, possible retaliation from an offender, and has received safety planning assistance from the treatment victim advocate.

3. Access to firearms

   Includes personal ownership of a firearm or living in a household with a firearm

   Do not score if the offender does not have access to firearms – for example if they are stored or locked elsewhere outside the home.

   If a court order is allowing the offender to have a weapon, this is still scored because the offender has access to a weapon.

Domain F: Criminal history – nondomestic violence (both reported and unreported to criminal justice system.

This information may be documented from probation reports, arrest records, or offender self-report.

This domain applies only to adult criminal history

1. Offender was on community supervision at the time of the offense

   This is a Critical Risk Factor that indicates initial treatment in Level C

   Community supervision includes supervised probation, unsupervised (court monitored) probation, parole, private probation, community corrections, pre-trial release, bond, etc.

2. Offender has a prior arrest for assault, harassment, or menacing

   If there have been two or more arrests, this is a Significant Risk Factor that indicates initial treatment in Level B at a minimum.

   Do not include a domestic violence enhanced crime

3. Prior nondomestic violence convictions at any time during offender's adult life

   Include any municipal, misdemeanor, and felony convictions.

   Includes all convictions except traffic violations

   Includes deferred sentence

   NOTE: IF the offender was scored on Domain B 2 only for two or more prior drug or alcohol treatment episodes during his/her lifetime DO NOT also score any related previous DUIs here.

4. Past violation(s) of conditional release or community supervision

   "Conditional release" includes probation, parole, bail, conditional discharge, suspended sentence, or any other occasion in which the offender is at liberty in the community under supervision or other requirements ordered by the court.

   Violation of a no contact order counts as violation of conditional release

5. Past assault of strangers, or acquaintances

   Assault includes physical assault, sexual assault and any use of a weapon.
   There does not have to be an arrest to code this item.
   Document how the information was obtained

6. Animal cruelty/abuse

   Includes threatening, abusing, or killing a family pet.
   There does not have to be an arrest to code this item.
   Document how the information was obtained

Domain G: Obsession with the victim (Current victim or current partner only)

1. Stalking or monitoring

Stalking , as defined by the National Center for Victims of Crime, Stalking Resource Center, is a pattern of repeated, unwanted attention, harassment, and contact. It is a course of conduct that can include:

- Following or laying in wait for the victim
- Repeated unwanted, intrusive, and frightening communications from the perpetrator by phone, mail, and/or e-mail
- Damaging the victim's property
- Making direct or indirect threats to harm the victim, the victim's children, relatives, friends, or pets
- Repeatedly sending the victim unwanted gifts
- Harassment through the Internet, known as cyberstalking, online stalking, or Internet stalking
- Securing personal information about the victim by: accessing public records (land records, phone listings, driver or voter registration), using Internet search services, hiring private investigators, contacting friends, family, work, or neighbors, going through the victim's garbage, following the victim, etc.

2. Obsessive jealousy with the potential for violence, violently and constantly jealous, or morbid jealousy.

- Morbid jealousy describes a range of irrational thoughts and emotions, together with associated unacceptable or extreme behavior, in which the dominant theme is a preoccupation with a partner's sexual unfaithfulness based on unfounded evidence.
- Individuals may suffer from morbid jealousy even when their partner is being unfaithful, provided that the evidence that they cite for unfaithfulness is incorrect and the response to such evidence on the part of the accuser is excessive or irrational.
- Morbidly jealous individuals interpret conclusive evidence of infidelity from irrelevant occurrences, refuse to change their beliefs even in the face of conflicting information, and tend to accuse the partner of infidelity with many others.

This domain could be scored with evidence of a protection order that is based on stalking or a violation of that type of protection order. A charge for stalking with the current victim would also result in a score on this item.

If the offender was scored for a civil protection order under Domain A.3 and the protection order is due to stalking, also score this Domain.

Domain H: Safety concerns

Information should not be used if it compromises victim safety and confidentiality and if the victim has not signed a written release of information specifically related to what information the victim is sharing. It is imperative that if the victim signs a release that allows this information to be utilized for scoring the DVRNA, she/he understands the ramifications of signing such a form, possible retaliation form an offender, and has received safety planning assistance from the treatment victim advocate. If the information is in the police report, the victim need not sign a release or give permission for this information to be used.

1. Victim perception of lack of safety/victim concerned for safety
2. Victim (female victim in heterosexual relationship) believes offender is capable of killing her

   NOTE: Even though threats of death are only scored for male offender against female victim, the MTT shall consider threats of death by the offender toward the victim regardless of gender and over ride the findings of the DVRNA if necessary.
3. Offender controls most of victim's daily activities
4. Offender tried to "choke" victim

   Although the medical terminology is "strangle", victims more readily identify with the word choke when reporting abuse.
5. Physical violence is increasing in severity
6. Victim forced to have sex when not wanted
7. Victim was pregnant at the time of the offense and offender knew this.
8. Victim is pregnant and offender has previously abused her during pregnancy.

Domain I: Violence and/or threatened violence toward family members including child abuse

This does not include criminal history. If there is criminal history related to this/these incident(s), score only on Domain F, number 3.

1. Current or past social services case as an adult where the offender was party to the action.

   Voluntary social services involvement is not scored. This item is intended to be open or past cases in social services.

2. Past assault of family members

   "Assault" includes physical assault, sexual assault, and any use of a weapon.

   "Family members" include biological and legal relatives (parents, step-parents, siblings, etc.), as well as children by previous or present intimate partners.

   Excludes previous or present intimate partners.

   Score even if there was no arrest conviction.

   May be obtained from credible offender self-report and written collateral reports.

3. Children were present during the offense (in the vicinity)

   A yes response would include any children in the home or location of offense even if they were sleeping, or it was perceived that they could not hear or see the offense.

   Include all children under of age of 18 regardless of their relationship to the victim and offender.

Domain J: Attitudes that support or condone spousal assault

Support or condone either implicitly or explicitly, by encouraging (a) patriarchy (male prerogative), (b) misogyny, and/or (c) the use of violence to resolve conflicts.

Multiple arrests for domestic violence **do not** implicitly or explicitly imply attitudes that support or condone spousal assault.

1. Explicitly endorses attitudes that support or condone intimate partner assault

   Explicit endorsed attitudes can be identified because they are precisely and clearly expressed or readily observable, leaving nothing to implication. It is expressed in a clear and obvious way, leaving no doubt as to the intended meaning.

   Examples include: offender calling the victim by derogatory names, stating that the victim/partner should obey the offender, lack of obedience is justification for abuse, stating that the victim is too stupid to handle money.

2. Appears to implicitly endorse attitudes that support of condone intimate partner assault.

   Implicit endorsed attitudes are suggested or understood without being directly stated. To imply is to suggest rather than to state. An action or incident can imply an idea that would otherwise have to be stated.

   Examples include: offender justifies behaviors that indicate the victim provoked him; such as she wouldn't stop talking or she was drunk. Offender provides covert messages around his/her true beliefs. Offender may verbally say he/she would not abuse his/her partner, but he/she is controlling and abusive by the actions of his/her behaviors.

Domain K: Prior completed or non-completed domestic violence treatment

Treatment occurred at any time in the past and was not completed, regardless of reason.

This information may be obtained from an Approved Provider or credible offender self-reports and written collateral reports from the criminal justice system.

Prior treatment that occurred at **any** time in the past regardless of the type of discharge received, whether successful, unsuccessful, or administrative.

Include any court-ordered or voluntary domestic violence treatment or counseling.

IF the offender is in treatment again for the same offense, this is not considered a new treatment episode for the purposes of this instrument and therefore it would not be scored.

Domain L: Victim separated from offender within the previous six (6) months

This refers to the risk of separation and is scored based on the *victim initiating the separation* from the offender within six months prior to the evaluation. Score this only when the victim has chosen to separate. This does not include the offender separating or a court order that requires they separate. Also score this item if the victim left and returned to the abuser.

It is a risk factor that can be reviewed at time of evaluation and calculated as the six (6) months previous to the evaluation.

Additionally, ***any*** time the victim initiates a separation from the offender this is a risk and needs to be scored and taken into consideration by the MTT. The MTT will determine on a case by case basis if the victim leaves during the offender's treatment whether this will impact level of treatment or treatment planning.

Separation refers to physical separation.

Separation may include entering a shelter, moving out of the residence, moving in with friends, or eviction of the offender.

Domain M: Unemployed

Do not count employment that is criminal in nature (e.g. drug dealing).

Unemployed is defined as not working at time of offense or at any time during intake or treatment and does not include offenders on public assistance, homemakers, students, or retirees.

An offender that is unemployed and collecting unemployment is scored as unemployed.

Domain N: Involvement with people who have pro-criminal influence

In order to score one point in this domain, *both* of the following factors shall be present.

1. Some criminal acquaintances

The presence of some criminal acquaintances is associated with an opportunity for pro-criminal modeling, a concept that is considered a major risk factor (Andrews & Bonta, 1994; Gendreau, 1995; Elliot et al., 1987; Hawkins & Lam, 1987).

Explore the scope of criminal involvement of the individual's network and to what degree it is an accepted norm.

- Score if the individual associates with (or did associate with prior to incarceration) some individuals who are not close friends, but are known to have criminal records or are known to be involved in criminal activity.
- Potential questions that can be asked: "Of the friends you just mentioned (reiterate by name if possible) which ones have been in trouble with the law, as far as you are aware?

For acquaintances or friends that have criminal records but are now clearly pro-social and stable, e.g., NA or AA sponsor with several years clean and sober, do not count these individuals as a pro-criminal influence

AND

2. Some criminal friends

Attachments to pro-criminal others is a well documented predictor of criminal behavior, with roots in both of the major explanatory theories in criminology: social control (Hirschi, 1969) and social learning (Akers & Burgess, 1968).

Inquire whether the offender's friends are known to be involved in unlawful behavior. Potential questions that can be utilized are: "You've indicated ____ and ____ and ____ are friends of yours. What kind of experience have they had with criminal behavior?"

Explore the criminal orientation (to what degree they participate or support unlawful activities) of the individual's friends.

- Score if the individual has friends (or did prior to incarceration) who are known to have criminal records or are known to be involved in criminal activity.
- Friends are associates with whom one spends leisure time, whose opinions are valued, who provide help when in difficulty, etc.

APPENDIX B – Annotated Domestic Violence Risk and Needs Assessment (DVRNA)

ANNOTATED DVRNA

(Domestic Violence Risk and Needs Assessment)

Prepared by Domestic Violence Unit

Division of Criminal Justice

Colorado Department of Public Safety

May 5, 2010

INTRODUCTION

The Domestic Violence Risk and Needs Assessment Instrument (DVRNA) is designed to identify risk factors that should be considered when working with domestic violence offenders in treatment. The DVRNA utilizes a structured decision-making process that improves the accuracy of decision-making based on risk assessment. This instrument presents a framework within which to assess the risk of future violence for domestic violence offenders in treatment. The DVRNA takes numerous risk factors that have been identified through empirical research as increasing the risk of violence or escalating its seriousness and consolidates these factors into a single measure, thus providing a method of determining the likelihood (probability) of ongoing or repeat violence.

The DVRNA was developed in conjunction with the revised *Standards for Treatment With Court Ordered Domestic Violence Offenders* Section 5.0 to address the different levels of treatment and how to classify an offender. Specifically, there is a need to be able to classify offenders according to risk because the research on offenders in general demonstrates that when risk corresponds to intensity of treatment, there is a greater possibility to reduce recidivism.

This instrument is comprised of 14 different empirically based domains of risk. Empirical evidence is used as a basis for the concept of differentiated treatment as well as to support each of the risk factors in the DVRNA. The basis of empirical evidence and previously validated instruments gives the DVRNA face validity. One of the tenets of the DVRNA is to guide initial treatment planning including the design of offender competencies that must be demonstrated by the offender and justification for changes to treatment plan, such as required additional treatment or reducing intensity of treatment.

The DVRNA has face validity. There is considerable consensus that risk assessment approaches must be rooted in the literature. The research has demonstrated that the most effective clinical assessment occurs with a validated risk assessment instrument in conjunction with clinical judgment. The DVOMB hopes to obtain funding in the future to perform a validation study on this risk assessment instrument.

Domestic violence risk assessment documents from other authors and "best practices" were evaluated. The primary risk assessment instruments utilized to create the DVRNA include the Spousal Assault Risk Assessment Guide, 2nd ed. (SARA), the Ontario Domestic Assault Risk Assessment, rev. ed. (ODARA), Level of Supervision Inventory, rev. (LSI VII), Domestic Violence Screening Instrument (DVSI), and the Danger Assessment Scale (Jacquelyn C. Campbell).

The most tested clinical assessment for assessing the risk of domestic violence is the SARA. The 20 factors included are characterized by criminal history, psychosocial adjustment, spousal assault history, and the index offense. Some items are related to the empirical research literature of the predictors of domestic violence or recidivism, whereas others were sectored on the basis of clinical experience. The ODARA is a 13-item actuarial risk assessment constructed specifically for wife assault. The items were derived from information available to, and usually recorded by police officers responding to domestic violence calls involving male perpetrators and female partners. The Level of Supervision Inventory (LSI) developed by Andrews and Bonta is a 54-item risk/need classification instrument. This instrument is composed of ten subscales that contain both "static" (e.g. criminal history) and "dynamic" (e.g. alcohol/drug problems, family/marital) risk factors.

The DVSI, developed by the Colorado Department of Probation Services consists of 12 social and behavioral factors found to be statistically related to recidivism by domestic violence perpetrators while on probation. These questions are designed to elicit information that is pertinent to determining an offenders' supervision level, including: (1) criminal history; (2) past domestic violence, alcohol, or substance abuse treatment; (3) past domestic violence restraining /protection orders, including violations; (3) previous non-compliance with community supervision, and (4) various other static and dynamic factors.

The Danger Assessment Scale developed by Jacquelyn Campbell for nurses, advocates, and counselors assesses the likelihood for spousal homicide. The first part of the tool assesses severity and frequency of battering by presenting the woman with a calendar of the past year. The second part includes yes-no questions that weigh lethality factors.

Risk factors were measured along two main dimensions. Criminogenic factors included substance abuse, psychopathy, pro offending attitudes and beliefs while the non-criminogenic dimension measured self-esteem, anger control, impulsiveness, anxiety, unemployment, social support and environmental factors. It was recognized that these dimensions did not act in isolation of each other, and any factor alone would not predict abusiveness.

The DVRNA cannot predict the behavior of any given individual. The single best predictor of future violent behavior continues to be past violence and we cannot, in any absolute sense, predict lethality or serious injury. The best we can do is to evaluate comparative risk and attempt to safeguard against identified dangers.

Guidelines for Use of the DVRNA

The following documentation is designed to be a resource for utilizing the DVRNA. Further explanations and definitions of the risk factors are provided here. These definitions are derived from the research that identified the risk factor. For several risk factors, there are numerous studies or articles identified. On occasion, the relevant portion of the study has been summarized for the purposes of this document.

The DVRNA includes 14 domains of risk that are identified as Domains A through N. When scoring the DVRNA, one should count a maximum of one point for each domain regardless of the number of items checked under each domain. Although there are sub-risk factors delineated under each domain, the maximum score for the entire instrument cannot exceed 14.

Domain A. Prior Domestic Violence Related Incidents (This domain applies only to adult criminal history):

1. Prior domestic violence conviction (ODARA, 2005) Critical Risk Factor that indicates initial treatment placement in Level C.
2. Violation of an order of protection (B-SAFER, 2005; Kropp & Hart, 2008; DVSI, 1998)
3. Past or present civil domestic violence related protection orders against offender.
4. Prior arrests for domestic violence (Ventura & Davis, 2004)
5. Prior domestic violence incidents not reported to criminal justice system (Cattaneo & Goodman, 2003).

The findings of the DVSI indicate that incidents involving multiple victims are highly associated with DVSI-R risk scores and recidivistic violence. Of the 12 items listed in the DVSI screening instrument, several items address domestic violence related incidents. These include prior arrests for assault, harassment, or menacing; and history of, and/or violations of domestic violence restraining order(s). The *Validation Study of the Domestic Violence Screening Instrument (2008)* reported that offenders arrested for violating a Temporary Restraining Order or Protective Order received the highest average DVSI score (11.56). Also, offenders arrested for "violating a temporary restraining order or protective order" accounted for the largest percentage of "high risk classifications" (64.9%).

The Ontario Domestic Assault Risk Assessment (ODARA) notes that a prior domestic incident whereby the offender assaulted his current or previous cohabiting partner and which is recorded in a police report or criminal record.

Domain B. Drug or Alcohol Abuse (Any of the following are Significant Risk Factors that indicate initial treatment placement in Level B at a minimum):

1. Substance abuse/dependence [as defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)]* within the past 12 months (B-SAFER, 2005; Cattaneo & Goodman, 2003; Kropp & Hart, 2008; ODARA, 2005; Weisz, et al., 2000); or "drunkenness"/intoxication (Gondolf, 2002)
2. History of substance abuse treatment within the past 12 months (Andrews & Bonta, 2005; Kropp & Hart, 2008; Saunders & Hamill, 2003; Klein, 2008) or two or more prior drug or alcohol treatment episodes during lifetime (DVSI, 1998)
3. Offender uses illicit drugs or illegal use of drugs (Campbell, 1995)

The involvement of alcohol or drugs is a significant predictor of subsequent arrest. This finding highlights the recognized interrelationship between alcohol/drug use and battering and the need for offenders to receive treatment for both problems (Hirschel et al., 2007)

Information was obtained from a multi-site evaluation to identify risk markers and batterer types that might help predict re-assault and repeat re-assault. The research team preformed a number of analyses in an attempt to identify risk markers. One finding indicated the strong risk marker for drunkenness and women's perception of safety and future assault. The substantial risk marker of drunkenness did not necessarily imply a causal link - that heavy alcohol use causes violence. Drunkenness may be a manifestation of an underlying need for power. Drunkenness coupled with previous violence may, furthermore, identify unruly men with chaotic and violent lifestyles or subcultures (Gondolf, 2002).

Recent substance abuse/dependence is identified as an item on the SARA Checklist, which identifies factors to consider when assessing the risk for future violence in domestic violence offenders. Recent substance misuse is associated with risk for violent recidivism among wife assaulters (Kropp & Hart, 2008). Additionally, the DVSI identifies "prior drug or alcohol treatment or counseling" as a factor in managing and predicting risk of future harm or lethality in domestic violence cases and the ODARA identifies substance abuse as a risk factor.

According to the results of a data collection project, performed by the Domestic Violence Offender Management Board staff utilizing over 5,000 responses, twenty-seven percent of offenders in domestic violence treatment also received drug and alcohol counseling, the most frequently identified adjunctive service (Henry, 2006).

Jacquelyn Campbell's research on femicide clearly indicates that perpetrator drug abuse significantly increased the risk of intimate partner femicide, but only before the effects of previous threats and abuse were added. Drug abuse, therefore, was associated with patterns of intimate partner abuse that increase femicide risks (Campbell et al, 2003).

In a study of 11,870 white men logistic models were used to estimate the odds of mild and severe husband-to-wife physical aggression. Being younger, having lower income, and having an alcohol problem significantly increased odds of either mild or severe physical aggression. Also, a drug problem uniquely increased the risk of severe physical aggression. Marital discord and depression further increased odds of aggression (Pan et al, 1994).

The prevalence of the overlap between substance abuse and relationship violence is generally high, and that this is most evident in high-risk samples (i.e. those that are positive on either relationship violence or substance abuse.). Research over the past 20 years has confirmed that substance use and abuse is a significant correlate of domestic physical violence. Longitudinal

investigations carried out in this area have yielded strong support for the causal role of husbands' heavy use of alcohol in the perpetration of male-to-female partner violence during the early years of marriage (Wekerle & Wall, 2002).

Domain C. Mental Health Issue (Any of the following are Significant Risk Factors that indicate initial treatment placement in Level B at a minimum):

1. Existing Axis I or II diagnosis (excluding V codes)
2. Personality disorder with anger, impulsivity, or behavioral instability (Kropp & Hart, 2008; B-SAFER, 2005)
3. Severe psychopathology (Gondolf, 2007; Huss & Langhinrichsen-Rohling, 2006))
4. Recent psychotic and/or manic symptoms (Kropp & Hart, 2008)
5. Psychological/psychiatric condition currently unmanaged
6. Noncompliance with prescribed medications and mental health treatment
7. Exhibiting symptoms that indicate the need for a mental health evaluation

Barbara Hart created a list of several indicators demonstrated by batterers who have killed or tried to kill their intimate partners. One such item listed is "depression." When a batterer has been acutely depressed and perceives little hope for overcoming the depression, he/she may be a candidate for homicide and suicide. Research demonstrates that many men who are hospitalized for depression have homicidal fantasies directed at family members (Hart, 1990).

Personality Disorder with Anger, Impulsivity, or Behavioral Instability is identified as an item in the SARA Checklist. Personality disorders characterized by anger, impulsivity, and behavioral instability (e.g., psychopathic/antisocial, borderline, narcissistic, or histrionic personality disorder) are associated with increased risk for criminal behavior, including violence and violent recidivism. In addition, "Recent Psychotic and/or Manic Symptom" is identified as an item on the SARA Checklist.

Edward Gondolf and colleagues investigated the psychological characteristics of the repeat re-assaulters in their multi-site evaluation by further interpreting the men's MCMI-III profiles. Approximately half of the repeat re-assaulters did show some evidence of psychopathic tendencies in the broadest sense of psychopathy. A relatively small portion (11%, about 1 in 10) of repeat re-assaulters exhibited primary psychopathic disorder – the classic coldhearted psychopathy of greatest concern. Nearly two thirds (60%) had sub-clinical or low levels of personality dysfunction (Gondolf, 2002).

Domain D. Suicidal/Homicidal: Serious homicidal or suicidal ideation/intent within the past year (Kropp & Hart, 2008)

1. Serious homicidal or suicidal ideation/intent within the past year (Kropp & Hart, 2008) Critical Risk Factor that indicates initial treatment in Level C
2. Ideation within the past 12 months (Kropp & Hart, 2008; B-SAFER, 2005).
3. Credible threats of death within the past 12 months (Kropp & Hart, 2008; Campbell, 2008)
4. Victim reports offender has made threats of harm/killing her (female victims in heterosexual relationships [6] (Campbell, 2008)

Homicidal or suicidal ideation within the past 12 months is a valid indicator that the perpetrator may continue to be violent towards his partner. Men who murder their intimate partners often report experiencing suicidal ideation or intent prior to committing their offense; in fact, it is not unusual for these men to attempt or even complete suicide after the murder. Moreover, empirical research suggests that there is a link between dangerousness to self and dangerousness to others (Kropp & Hart, 2008; Campbell, 2008).

"The more the batterer has developed a fantasy about who, how, when, and/or where to kill, the more dangerous he may be. The batterer who has previously acted out part of a homicide or suicide fantasy may be invested in killing as a viable 'solution' to his problems. As in suicide assessment, the more detailed the plan and the more available the method, the greater the risk" (Hart, 1995).

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

1. Gun in the home in violation of a civil or criminal court order (Vigdor & Mercy, 2006) Critical Risk Factor that indicates initial treatment in Level C.
2. Use and/or threatened use of weapons in current or past offense (Kropp & Hart, 2008; Azrael & Hemenway, 2000, Hart, 1990)
3. Access to firearms (Langley, 2008; Paulozzi et al. 2001; Mitchell & Carbon, 2002; Campbell, 2003; Saltzman, et al.,1992; Klein, 2008). "Access" to firearms is defined as personal ownership of a firearm or living in a household with a firearm.

A 2000 study by Harvard School of Public Health researchers analyzed gun use at home and concluded: "hostile gun displays against family members may be more common than gun used in self-defense, and that hostile gun displays are often acts of domestic violence against women." This study presents results from a national random digit dial telephone survey of 1,906 U.S adults conducted in the spring of 1996. Respondents were asked about hostile gun displays and use of guns and other weapons in self-defense at home in the past five years. The

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

objective of the survey was to assess the relative frequency and characteristics of weapons-related events at home (Azrael & Hemenway, 2000).

A study by the Centers for Disease Control and Prevention regarding homicide among intimate partners found that female intimate partners were more likely to be murdered with a firearm than by all other means combined. Women who were previously threatened or assaulted with a firearm or other weapons were 20 times more likely to be murdered by their abuser than other abused women. The study concluded that the figures demonstrate the importance of reducing access to firearms in households affected by intimate partner violence (Paulozzi, et al., 2001).

Risk factors identified among a majority of experts include access to/ownership of guns, use of weapons in prior abusive incidents, and threats with weapon(s) (Campbell, 1995).

Abusers' previous threats with a weapon and threats to kill were associated with substantially higher risks for femicide. Campbell's research indicates that abusers who possess guns tend to inflict the most severe abuse. Additionally, gun owning abusers' have a much greater likelihood of using a gun in the worst incident of abuse, in some cases, the actual femicide. (Campbell et al., June 2003).

In an analysis of the danger assessment risk factors, 15 of the 17 items distinguished intimate partner homicide victims from abused women. The factor with the strongest risk (highest odds ration) was use (or threatened use) of a weapon. Those women were 20 times more likely to be killed as other abused women (Campbell et al., 2004).

The SARA utilizes the indicator, "use of weapons and/or credible threats of death in the most recent incident" as an indicator of abuse. "Credible" means the threats were perceived as credible by the victim (e.g., "I'll get you") (Kropp & Hart, 2000).

Considerable research suggests that the likelihood of death in an expressive assault is related to the availability of a weapon. (Saltzman, et al., 1992) have reported that overall firearm-associated family and intimate assaults were 12 times more likely to be fatal than non-firearm associated family and intimate assaults.

Domain F. Criminal History – Nondomestic Violence (Both Reported and Unreported to the Criminal Justice System) (This domain applies only to adult criminal history):

1. Offender was on community supervision at the time of the offense (DVSI, 1998) Critical Risk Factor that indicates initial treatment in Level C)
2. Offender has a prior arrest for assault, harassment, or menacing (DVSI, 1998; Buzawa, et al., 2000; Ventura & Davis, 2004) If there have been two or more arrests, it is a Significant Ruisk factor that indicates initial treatment in Level B at a minimum.
3. Prior nondomestic violence convictions (DVSI, 1998; Klein, 2008; ODARA, 2005; Ventura & Davis, 2004)
4. Past violation(s) of conditional release or community supervision (bail, probation - Kropp & Hart, 2008; B-SAFER, 2005; ODARA, 2005).
5. Past assault of family members, strangers, or acquaintances (Kropp & Hart, 2008; Weisz, et al., 2000; B-SAFER, 2005)
6. Animal cruelty/abuse (Humane Society, 2007; Volant et al., 2008; Ascione, 1998; Faver & Strand, 2003; Ascione, 2007; Ascione, et al., 2007).

Criminal history is an important part of risk assessment. It is a long-established predictor of future behavior. The versatility, stability, and frequency of the offender's criminal behavior patterns are key risk factors for recidivism (Andrews & Bonta, 2005).

Offenders with a history of violence are at increased risk of spousal violence, even if the past violence was not directed towards intimate partners or family members. Research has shown that generally violent men engage in more frequent and more severe spousal violence then do other wife assaulters (Kropp & Hart, 2008).

Of the 12 items listed in the DVSI screening instrument, questions were designed to elicit information regarding an offender's criminal history. These include prior non-domestic violence convictions and history of any form of community supervision at time of offense. Offenders who have violated the terms of conditional release or community supervision are more likely to recidivate than are other offenders. In a validation study of the DVSI based on all DVSI assessment completed between August 2003 and July 2007 by the State of Hawaii, the most commonly reported risk factor (43.5%) was prior non-domestic violence convictions (Hisashima, 2008).

A study using data from the Spousal Assault Replication Program (SARP), sponsored by the National Institute of Justice examined (1) the extent to which criminal domestic violence offenders specialize in violence and (2) whether the severity of an offender's attacks against the same victim increase, decrease or stay about the same over time. The specialization analysis revealed that criminal domestic violence is part of a larger cluster of serious problem behaviors in the lives of the people who commit it. Few SARP domestic violence offenders had been specializing exclusively in violence. Many offenders were identified with violence in their

official criminal histories, but the overwhelming majority of these individuals also committed nonviolence offenses. The domestic violence offender who is arrested only for violent criminal activity appears to be the exception rather than norm (Piquero et al., 2005).

Most studies agree that the majority of domestic violence offenders that come to the attention of the criminal justice system have a prior criminal history for a variety of non-violent and violent offenses, against males as well as females, domestic and non-domestic. A study of intimate partner arrests in Connecticut, Idaho, and Virginia of more than a thousand cases, for example, found that almost seventy percent (69.2%) had a prior record, 41.8% for a violent crime (Hirschel, et al., 2007).

A study of the Cook County (Chicago) misdemeanor domestic violence court found that about three-quarters of defendants had a prior domestic abuse charge, and over 80% had a prior simple assault charge. Fifty seven percent of the men charged with misdemeanor domestic violence had prior records for drug offenses, 52.3% for theft, 30.8 % for weapons violations, 68.2% for public offenses, and 61.2% for property crimes. These men averaged 13 prior arrests (Hartley & Frohmann, 2003).

Not only did most of the abusers brought to the Toledo Ohio Municipal Court for domestic violence have a prior arrest history, but the average number of prior arrests was fourteen. A majority of batterers (69%) had been arrested for at least one violent misdemeanor, including and in addition to domestic violence. And 89 percent had been arrested for one or more non-violent misdemeanor (Ventura & Davis, 2004).

Similarly, 84.4 percent of domestic violence offenders in a study performed in Massachusetts were previously arrested for a wide variety of criminal behaviors; 54 percent having 6 or more criminal charges (Buzawa et al., 2000).

Animal Cruelty

Batterers tend to threaten, abuse, or kill animals to demonstrate and confirm power and control over the family, to isolate the victim and children, to teach submission, to perpetuate the context of terror, and to punish the victim for leaving. A 1997 survey of 50 of the largest shelters for battered women in the United States found that 85% of the agencies surveyed reported that women discuss pet abuse. Additionally, 63% of the shelters surveyed reported that children entering their shelters discussed incidents of companion animal abuse (Ascione et al., 1997).

Studies reviewed confirm that pet abuse by intimate partners is a common experience for women who are battered. If children are present, they are often exposed to pet abuse – an experience that may compromise their physical and mental health. Family pets may become pawns in a sometimes deadly form of coercion and terrorizing used by some batterers. Women's concerns about the welfare of their pets may be an obstacle to fleeing violence partners and may affect women's decision making about staying with, leaving, and/or returning to batterers (Ascione, 2007).

Domain G. Obsession with the Victim:

1. Stalking or monitoring (Campbell, 1995; Block, Campbell, & Tolman (2000)
2. Obsessive jealousy with the potential for violence, violently and constantly jealous, morbid jealousy (Wilson & Daly, 1992; Hilberman & Munson, 1978; Campbell et al., 2003)

Stalking

Stalking refers to repeated harassing or threatening behaviors that an individual engages in such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property. These actions may be accompanied by a credible threat of serious harm, and they may or may not be precursors to an assault or murder (Tjaden & Thoennes, 2000).

Stalking is a crime of intimidation. Stalkers harass and even terrorize through conduct that causes fear or substantial emotional distress in their victims. Stalking is defined as "the willful or intentional commission of a series of acts that would cause a reasonable person to fear death or serious bodily injury and, in fact, does place the victim in fear of death or serious bodily injury" (OVC, 2002).

Stalking is identified as a risk factor for both femicide and attempted femicide as research has demonstrated that stalking is revealed to be correlated with lethal and near lethal violence against women. Jacqueline Campbell's *Danger Assessment* lists violent and constant jealousy as a risk factor associated with homicide.

A study was undertaken to examine what factors predict the occurrence of stalking in relationships characterized by domestic violence, via in-depth interviews with victims of domestic violence whose cases had gone through the criminal justice system. The study found that the experience of stalking by the victims' abusers was very prevalent. In addition,

victims who have experienced stalking within their relationships characterized by domestic violence are at a greater risk for experiencing more stalking (by their abuser) in the future (Melton, 2007).

A study was completed that described the frequency and type of intimate partner stalking that occurred within 12 months of attempted and actual partner femicide. One hundred forty-one femicide and 65 attempted femicide incidents were evaluated. The prevalence of stalking was 76% for femicide victims and 85% for attempted femicide victims. Incidence of intimate partner assault was 67% for femicide victims and 71% for attempted femicide victims. A statistically significant association exists between intimate partner physical assaults and stalking for femicide victims as well as attempted femicide victims. Stalking is revealed to be a correlate of lethal and near lethal violence against women and, coupled with physical assault, is significantly associated with murder and attempted murder. Stalking must be considered a risk factor for both femicide and attempted femicide (McFarlane et al., 1999).

Jealousy

Jealousy (as distinct from envy) refers to a complex mental state or "operating mode" activated by a perceived threat that a third party might usurp one's place in a valued relationship. It motivates any of various circumstantially contingent responses, ranging from vigilance to violence, aimed at countering the threat (Mullen & Martin, 1994).

Wilson and Daly (1996) report that battered women nominate "jealously" as the most frequent motive for their husbands/ assaults, and their assailants commonly make the same attribution. Wilson and Daly (1993) report the following: "Although wife beating is often inspired by a suspicion of infidelity, it can be the product of a more generalized proprietariness. Battered women commonly report that their husbands object violently to the continuation of old friendships, even with other women, and indeed to the wives' having any social life whatever.

In a study of 60 battered wives who sought help at a clinic in rural North Carolina, (Hilberman & Munson, 1978) "found pathological jealously to be a cornerstone to homicidal rage in their study of family violence in North Carolina." They reported that the husbands exhibited morbid jealousy, such that leaving the house for any reason invariably resulted in accusations of infidelity that culminated in assault in 57 percent of the cases.

Domain H. Safety Concerns (The ultimate goal in reviewing and utilizing information is to protect the victim. Information shall not be used if it compromises victim and confidentiality – refer to *Standard* 5.04 II):

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

Offender Controls

Several risk factors have been identified with homicide of battered women, which include offender's control of victim's daily activities and offenders' attempts to choke victim. Jacquelyn Campbell uses past incidences of strangulation as an indicator of abuse. Her research indicates that 84 of the 220 victims, or 57.1 % of homicide in her study regarding femicide had been killed by partners who had tried to "choke (strangle)" them at some time in their relationship (Campbell, 1995).

Offender Tried to Strangle Victim

In an analysis of the danger assessment risk factors, 15 or the 17 items distinguished intimate partner homicide victims from abused women. The factor with the third strongest risk (highest odds ration) was offender tried to choke (strangle) her. Those women were nine times more likely to be killed as other abused women (Campbell et al., 2004).

Physical Violence Increasing

It has long been observed that a pattern of recent escalation in the frequency or severity of assault is associated with imminent risk for violent recidivism. According to research done in the health care setting by Jacqueline Campbell, "The trajectory of the most severe kinds of abuse is often an increase in severity and frequency over time that may culminate in a homicide if the woman does not leave or the man does not receive treatment or is not incarcerated for violence" (Campbell & Boyd, 2003).

Forced Sex

Sexual assault or forced sex is another facet of approximately 40 to 45 percent of battering relationships. Sexual assault is defined as sexual acts coerced by physical force or threats or by power differentials. Two sample descriptive studies found battered women forced into sex by an intimate partner were also subject to more severe physical abuse and greater risk of homicide (Campbell & Boyd, 2003).

Victim was Pregnant

Victims who are pregnant may suffer from more prevalent and severe abuse. "In several descriptive studies, battering during pregnancy has been associated with severe abuse, weapon carrying and threats by the abuser, and risk of homicide, suggesting that the man who beats his pregnant partner is an extremely dangerous man" (Campbell & Boyd, 2003).

One of the few qualitative data analyses related specifically to abuse during pregnancy, demonstrated that differing patterns of abuse occur during pregnancy according to the women abused. In a small percentage (15 percent) of the sample, women whose partners thought the baby was not his said their partners abused them most severely during pregnancy and seemed to be trying to cause a miscarriage. This is an important finding, given the link demonstrated in population-based studies between stepchildren and both female spouse and child homicide. Another group of women (19 percent), more likely to be in their first pregnancy, found their husbands to be jealous of their attachment to the unborn child. A third group (15 percent) said that the abuse was pregnancy specific but not related to the child. These two patterns may help explain the reports of some battered women who say the abuse first started or became exacerbated during pregnancy. However, the largest group of women (46 percent) reported that abuse during pregnancy was just a continuation of abuse that occurred before the pregnancy. This illustrates findings found in larger studies indicating that` the major risk factor for abuse during pregnancy is abuse prior to pregnancy. This study also found that a substantial proportion of women (53 percent of a convenience sample of 61 battered women) were abused before and after pregnancy but not during pregnancy. The few larger studies that have looked at prevalence before and after pregnancy have also found this pattern (Campbell & Boyd, 2003).

A study was performed to identify risk factors for pregnancy-associated homicide (women who died as a result of homicide during or within 1 year of pregnancy) in the United States from 1991 to 1999. Pregnancy-associated homicides were analyzed with data from the Pregnancy Mortality Surveillance System at the Centers for Disease Control and Prevention.

Six hundred seventeen (8.4%) homicide deaths were reported to the Pregnancy Mortality Surveillance System. The pregnancy-associated homicide ratio was 1.7 per 100000 live births. Overall firearms (56.6%) were the leading mechanism of pregnancy-associated homicide. The study concluded that homicide is a leading cause of pregnancy-associated injury deaths (Chang, et al., 2005).

To describe the odds of femicide for women abused during pregnancy, a ten city case control design was used with attempted and completed femicides (n=437) and randomly identified abused women living in the same metropolitan area as controls (n=384). Abuse during pregnancy was reported by 7.8% of the abused controls, 25.8% of the attempted femicides, and 22.7% of the completed femicides. After adjusting for significant demographic factors, it was determined that the risk of becoming an attempted or completed femicide victim was three-folder higher (McFarlane, et al., 2002).

To determine the frequency, severity, and perpetrator of abuse during pregnancy as well as the occurrence of risk factors of homicide, an analysis was complete on African-American, Hispanic, and Anglo women in public health prenatal clinics. All women were assessed for abuse at the first prenatal visit and twice more during pregnancy. Prevalence of physical or sexual abuse during pregnancy was 16 percent (1 of 6). Abuse was recurrent, with 60 percent of the women reporting repeated episodes (McFarlane et al., 1996).

Victim's Perception of Safety

Weisz and colleagues performed a study from secondary data analysis comparing the accuracy of 177 domestic violence survivors' predictions of re-assault to risk factors supported by research. The item that was the single best predictor of severe violence was the women's perception of risk (Weisz, et al., 2000).

Gondolf and Heckert `performed a study that partially replicated and expanded on a previous study that demonstrated women's perceptions of risk to be a strong predictor of re-assault among batterers. This study employed a multi-site sample, a follow-up period of 15 months, and multiple outcomes including repeated re-assault. The study's use of multinomial logistic regressions demonstrated how well women's perceptions of risk predict multiple outcomes and especially repeated re-assault (Gondolf & Heckert, 2004).

Domain I. Violence and/or Threatened Violence Toward Family Members Including Child Abuse (Does not include intimate partners):

1. Current or past social services case
2. Past assault of family members (Kropp & Hart, 2008)
3. Children were present during the offense (in the vicinity) (DVSI, 1998).

As defined by the SARA, family members include biological and legal relatives (parents, step-parents, siblings, etc.), as well as children from past or present intimate partners, but exclude past or present intimate partners. One of the most common research findings is that offenders with a history of violence are much more likely to engage in future violence than are those with no such history. Research has also demonstrated that wife assaulters who have a history of physical or sexual violence against family members are at increased risk for violent recidivism (Kropp & Hart, 2008).

Nationally, the reported rate of overlap between violence against children and violence against women in the same families is 30 to 60 percent. Although the studies on which this information is reported are based utilizing different methodologies (e.g., case record reviews, case studies, and national surveys), using different sample sizes, and examining different populations, they consistently report a significant level of co-occurrence (U.S. DHHS, 1999).

Child abuse and domestic violence often occur in the same family and are connected in many ways that may have serious consequences for the safety of all family members. Research shows that the impact on children of witnessing parental domestic violence is strikingly similar to the consequences of being directly abused by a parent. Many of the factors highly associated with the occurrence of child abuse are also associated with domestic violence (Carter, 2000).

The U.S. Department of Health, Education and Welfare reported that children from homes where the wife is battered are at a very high risk to receive their father's abuse. Research studies suggest links between child abuse and spousal abuse as evidenced by a study of 1,000 women (225 did not have children with the batterer). Those offenders who abused their spouses abused children in 70% of the families in which children were present. This study concluded that children of battered wives are very likely to be battered by their fathers and the severity of the spousal beating is predictive of the severity of child abuse (Yllo & Bograd, 1990).

Child abuse and domestic violence co-occur in an estimated 30 to 60 percent of the families where there is some form of family violence according to a 2004 report by the Children's Defense Fund entitled *The State of America's Children 2004*.

The DVSI identifies "children present during the offense (in the vicinity)" as a factor in managing and predicting risk of future harm or lethality in domestic violence cases.

Domain J. Attitudes That Support or Condone Spousal Assault:

1. Explicitly endorses attitudes that support or condone intimate partner assault (Kropp & Hart, 2008; B-SAFER, 2005).
2. Appears to implicitly endorse attitudes that support or condone intimate partner assault (Kropp & Hart, 2008; B-SAFER, 2005)..

Negative attitudes about spousal assault include beliefs and values that directly or indirectly encourage or excuse abusive, controlling and violent behavior. Such attitudes include sexual jealousy, misogyny, and patriarchy. Also included is minimization or denial of violent actions of the serious consequences of those actions (B-SAFER, 2002).

The SARA includes "attitudes that support or condone spousal assault" as a risk factor for repeated spousal violence because large-scale survey research, other empirical studies, and clinical observation suggest that a number of sociopolitical, religion, cultural, and personal attitudes differentiate between men who have recently assaulted their partners and those who have not. A common thread running through these attitudes is that they support or condone wife assault implicitly or explicitly. Such attitudes often co-exist with minimization/denial of wife assault, and are associated with increased risk of violent recidivism (Kropp & Hart, 2008).

Domain K. Prior Completed or Non-completed Domestic Violence Treatment:

- (DVSI, 1998; Hisashima, 2008; Stalans et al., 2004)

Prior domestic violence treatment or counseling whether court-ordered or voluntary is an item included on the Domestic Violence Screening Instrument (DVSI). A validation study of the DVSI was recently completed by the Hawaii State Department of Health. This analysis indicated that prior domestic violence treatment was reported in 24.9% of the assessments. This study concluded that the DVSI analyses indicate that the instrument is accurately classifying offenders based on risk (Hisashima, 2008)

A study funded by the Illinois Criminal Justice Information Authority addressed whether three groups of violent offenders have similar or different risk factors for violent recidivism while on probation. It concluded that for generalized aggressors and family only batterers, treatment compliance was an important risk predictor of violent recidivism (Stalans et al., 2004).

Domain L. Victim Separated from Offender Within the Previous Six Months:

- (DVSI, 1998; Hisashima, 2008; Wilson & Daly, 1993; Campbell, et al., 2003)

The DVSI defines separation as the following: (1) physical separation (2 going into shelter, moving out, moving in with friends, or evicted by the defendant. In a validation study of the DVSI based on all DVSI assessments completed by the State of Hawaii between August 2003 and July 2007, victims separated from offenders within the previous six months represented the second most commonly reported risk factor (38.5%).

An examination of uxoricide (murder of one's wife) in Canada reported that if violence or threats of violence are used as a way to limit female autonomy, men may be motivated to act in these ways in response to probabilistic cues of their wives' likelihood or intention of desertion. It follows that resolving to leave one's husband may be associated with elevated risk of violence, including risk of being killed (Wilson, et al., 1993). The results of a multi-site case control study concluded that "the risk of intimate partner femicide was increased nine-fold by the combination of a highly controlling abuser and the couple's separation after living together" (Wilson et al., 1993).

Domain M.: Unemployed

- (DVSI, 1998; Kyriacou, et al., 1999; Campbell, et al., 2003; Benson & Fox, 2004; B-SAFER, 2005)
- Unemployed is defined as not working at time of the offense or at any time during intake or treatment and does not include offenders on public assistance, homemakers, students, or retirees

Unemployment has been shown to be an important risk factors used for predicting intimate partner femicide. In a study that compared femicide perpetrators with other abusive men, the conclusion was that unemployment was the most important demographic risk factor for acts of intimate partner femicide. In fact, an abuser's lack of employment was the only demographic risk factor that significantly predicted femicide risks (Campbell et al., 2003).

In a validation study of the DVSI based on all DVSI assessment completed between August 2003 and July 2007 by the State of Hawaii, unemployment represents the fourth (35.4%) most commonly reported risk factor (Hisashima, 2008).

The Level of Supervision Inventory (LSI) Criminal History Scale identifies job stability as a major factor in reducing recidivism. "A history of poor job performance and attitude signifies disregard for pro-social reinforcements. Lack of consistent employment reflects a higher risk for return to criminal lifestyle." (Andrews & Bonta, 2005).

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

1. Some criminal acquaintances
   The presence of some criminal acquaintances is associated with an opporutunity for pro-criminal modeling, a concept that is considered a major risk factor (Andrews & Bonta, 2005)

AND

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

"Uncaring, negative, or hostile relationships with relatives who have frequent contacts are indicative of poor social and problem-solving skills and a lack of pro-social modeling. Criminal family member(s) indicate negative modeling and exposure to pro-criminal influence and/or vicarious reinforcement of anti-social attitude and behaviors. The lack of anti-criminal companions indicates two things: first, there is less of an opportunity to observe pro-social models, and secondly, there is an absence of companions who can actively reinforce pro-social behavior and punish undesirable behavior.

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APPENDIX C – The Domestic Violence Risk and Needs Assessment (DVRNA) Score Sheet

Colorado Domestic Violence Offender Management Board
Standards For Treatment With Court Ordered Domestic Violence Offenders

Domestic Violence Risk & Needs Assessment (DVRNA)
Scoring Sheet

Name: _____ Client Number: _____ Date: _____
Client date of birth: _____ Client SSN: _____ Client State ID: _____
Supervising Agency/Officer: _____ Case: _____

THIS IS A REQUIRED FORM.

ONLY SCORE INFORMATION RELATED TO THE OFFENDER AS AN ADULT

A. Prior domestic violence related incidents — Yes

1. Prior domestic violence conviction ..... Critical Risk Factor--Level C ☐

Any of the following are Significant Risk Factor — Level B (minimum) — Yes

2. Violation of an order of protection (documented violation) ..... ☐
3. Past or present civil domestic violence related protection orders against offender ..... ☐
4. Prior arrests for domestic violence. ..... ☐
5. Prior domestic violence incidents not reported to criminal justice system. ..... ☐

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

Identify Level B or Level C _____

B. Drug or alcohol abuse — Yes

Any of the following are Significant Risk Factor—Level B (minimum) — Yes

1. Substance abuse/dependence within the past 12 months. ..... ☐
2. History of substance abuse treatment within the past 12 months or 2 or more prior drug or alcohol treatment episodes during lifetime. ..... ☐
3. Offender uses illegal drugs or illegal use of drugs. ..... ☐

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

Level B _____

C. Mental health issue — Yes

Any of the following are Significant Risk Factor—Level B (minimum) — Yes

1. Existing Axis I or II diagnosis (excluding V codes) ..... ☐
2. Personality disorder with anger, impulsivity, or behavioral instability. ..... ☐
3. Severe psychopathology. ..... ☐
4. Recent psychotic and/or manic symptoms. ..... ☐
5. Psychological/psychiatric condition currently unmanaged. ..... ☐
6. Noncompliance with prescribed medications and mental health treatment. ..... ☐
7. Exhibiting symptoms that indicate the need for a mental health evaluation. ..... ☐

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

Level B _____

7/10

Appendix G-III-1
(DVRNA Scoring Sheet)

D. Suicidal/homicidal	Yes
1. Serious homicidal or suicidal ideation/intent within the past year. . . . . Critical Risk Factor--Level C	☐
	Yes
2. Ideation within the past 12 months	☐
3. Credible threats of death within the past 12 months.	☐
4. Victim reports offender has made threats of harming/killing her (female victims in heterosexual relationships)	☐
Information Sources: _____ Domain D—Criteria Met	☐
Level C _____	

E. Use and/or threatened use of weapons in current or past offense or access to firearms.	Yes
1. Gun in the home in violation of a civil or criminal court order . . . . . Critical Risk Factor--Level C	☐
2. Use and/or threatened use of weapons in current or past offense . . . . . Critical Risk Factor--Level C	☐
	Yes
3. Access to firearms	☐
Information Sources: _____ Domain E—Criteria Met	☐
Level C _____	

F. Criminal history-nondomestic violence (both reported and unreported to criminal justice system). This domain applies only to adult criminal history.	Yes
1. Offender was on community supervision at the time of the offense . . . . Critical Risk Factor--Level C	☐
2. Offender has a prior arrest for assault, harassment, or menacing. If there have been two or more arrests, it is a . . . . . Significant Risk Factor--Level B (minimum)	☐
	Yes
3. Prior nondomestic violence convictions	☐
4. Past violations of conditional release or community supervision	☐
5. Past assault of strangers, or acquaintances	☐
6. Animal cruelty/abuse	☐
Information Sources: _____ Domain F—Criteria Met	☐
Identify Level B or Level C _____	

Appendix G-III-2
(DVRNA Scoring Sheet)

7/10

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

H. Safety concerns The ultimate goal in reviewing and utilizing information is to protect the victim. Information shall not be used if it compromises victim safety and confidentiality. (Refer to Standard 5.04 II) Yes		Yes
1. Victim perception of safety/victim concerned for safety	☐	
2. Victim (female victim in heterosexual relationship) believes offender is capable of killing her.	☐	
3. Offender controls most of victim's daily activities	☐	
4. Offender tried to "choke" victim.	☐	
5. Physical violence is increasing in severity.	☐	
6. Victim forced to have sex when not wanted.	☐	
7. Victim was pregnant at the time of the offense and offender knew this.	☐	
8. Victim is pregnant and offender has previously abused her during pregnancy.	☐	
Information Sources: _____ Domain H—Criteria Met		☐

I. Violence and/or threatened violence toward family members, including child abuse (does not include intimate partners)	Yes	Yes
1. Current or past social services case(s).	☐	
2. Past assault of family members	☐	
3. Children were present during the offense.	☐	
Information Sources: _____ Domain I—Criteria Met		☐

Appendix G-III-3
(DVRNA Scoring Sheet)

7/10

J. Attitudes that support or condone spousal assault

	Yes	Yes
1. Explicitly endorses attitudes that support or condone intimate partner assault.	☐	
2. Appears to implicitly endorse attitudes that support or condone intimate partner assault.	☐	
Information Sources: _____ Domain J—Criteria Met		☐

K. Prior completed or noncompleted domestic violence treatment

	Yes
Information Sources: _____ Domain K—Criteria Met	☐

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

	Yes
Information Sources: _____ Domain L—Criteria Met	☐

M. Unemployed

Unemployed is defined as not working at time of offense or at any time during intake or treatment and does not include offenders on public assistance, homemakers, students, or retirees.

	Yes
Information Sources: _____ Domain M—Criteria Met	☐

N. Involvement with people who have pro-criminal influence

	Yes	Yes
1. Some criminal acquaintances.	☐	
AND		
2. Some criminal friends.	☐	
Information Sources: _____ Domain N—Both Criteria Met		☐

Appendix G-III-4
(DVRNA Scoring Sheet)

7/10

Colorado Domestic Violence Offender Management Board
Standards For Treatment With Court Ordered Domestic Violence Offenders

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

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

Level A = 0 - 1 risk factors met

Level B = 2 - 4 risk factors met

Level C = 5 or more risk factors met

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

Appendix G-III-5
(DVRNA Scoring Sheet)

7/10

Comments: _____

_____

_____

_____

_____

_____

Override Reasons: _____

_____

_____

_____

_____

_____

Information Source Codes

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

_____

Document or Verify Consensus of MTT

Evaluator _____ Date _____

Probation _____ Date _____

Victim's Advocate _____ Date _____

Appendix G-III-5
(DVRNA Scoring Sheet)

7/10

APPENDIX D – Tracking Offenders in Treatment Data Collection Form

DVOMB TRACKING OFFENDER IN TREATMENT PROJECT 2011-2013

***PLEASE USE THIS FORM ONLY FOR OFFENDERS* WHO BEGAN TREATMENT AFTER SEPTEMBER 2011**

Treatment Provider Name: _____

Offender Gender: _____

County Where Treatment is Given: _____

Date of Initial Intake Evaluation: _____

Probation

Was Probation extended for treatment reasons? Yes No

If Probation was extended for treatment reasons, please explain why?

_____
_____

Original Placement

Original DVRNA Level Recommended (as a result of DVRNA scoring)

Level A ☐ Level B ☐ Level C ☐

If there is an Initial Override, what Level was the offender placed?

Level A ☐ Level B ☐ Level C ☐

Reason for Override:

_____
_____

Additional Changes to Level of Treatment for This Client

Date of Change	Current Level	Length of Time at This Level	Changed to Level	Reason for Change

Total Length of Treatment (weeks): _____

Reason for Discharge:

Completed Treatment ☐ Unsuccessful Discharge ☐ Administrative Discharge ☐

Treatment Level at Discharge: Level A ☐ Level B ☐ Level C ☐

APPENDIX E – Provider Implementation Survey Questionnaire

Purpose of the Study: We are asking you to take part in a research study by the Domestic Violence Offender Management Board (DVOMB). The purpose of this research is two-fold: (1) gather information related to the implementation of the 2010 DVOMB Standards and (2) gather information regarding MTT decision-making and offender risk assessment/reassessment with the DVRNA. You are being asked to take part in a one-time online survey (20 to 30 minutes). The survey responses will be de-identified and kept confidential. A target number of 200 MTT members will be surveyed.

Study Procedures: If you take part in this study, you will be asked to respond to a one-time online survey that will take approximately 20 to 30 minutes. The survey is available via Survey Monkey, a popular online survey mechanism. When recalling past events in your own community, we ask that you not provide any identifying information to ensure the privacy of individuals involved. You are free to decide not to answer any question/s. Also, you are free to withdraw from this study at any time.

Benefits: There are no direct benefits to you for participating in this study. However, this study will provide valuable information regarding the current practices of DVOMB approved providers, the degree of implementation of the Standards and MTT decision-making process for assessing/reassessing domestic violence offender risk.

Risks or Discomfort: This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study. Survey responses will be ANONYMOUS and kept CONFIDENTIAL. Results will be presented in the aggregate and no identifying information will be released.

Compensation: Individuals will not be compensated for their participation.

Privacy and Confidentiality: We will keep all survey responses private and confidential. Certain people may need to see the survey responses. By law, anyone who looks at the survey responses must keep them completely confidential. The only people who will be allowed to see these responses is Jesse Hansen (staff researcher to the DVOMB).

Voluntary Participation / Withdrawal: You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty if you stop taking part in this study. If you have any questions, concerns or complaints about this study, experience an adverse event or unanticipated problem, or if have questions about your rights as a participant in this study, or general questions call Jesse Hansen at 303-239-4592 or email him at jesse.hansen@state.co.us.

Consent to Take Part in this Research Study

It is up to you to decide whether you want to take part in this study. If you want to take part, please click "yes" at the bottom of this form, if the following statement is true.

I freely give my consent to take part in this study. I understand that by clicking "yes" I am agreeing to take part in research.

- O Yes
- O No

Question 1: Which county do you work in?

- ☐ Adams County
- ☐ Alamosa County
- ☐ Arapahoe County
- ☐ Archuleta County
- ☐ Baca County
- ☐ Bent County
- ☐ Boulder County
- ☐ City & County of Broomfield
- ☐ Chaffee County
- ☐ Cheyenne County
- ☐ Clear Creek County
- ☐ Conejos County
- ☐ Costilla County
- ☐ Crowley County
- ☐ Custer County
- ☐ Delta County
- ☐ City and County of Denver
- ☐ Dolores County
- ☐ Douglas County
- ☐ Eagle County
- ☐ Elbert County
- ☐ El Paso County
- ☐ Fremont County
- ☐ Garfield County
- ☐ Gilpin County
- ☐ Grand County
- ☐ Gunnison County
- ☐ Hinsdale County
- ☐ Huerfano County
- ☐ Jackson County
- ☐ Jefferson County
- ☐ Kiowa County
- ☐ Kit Carson County
- ☐ La Plata County
- ☐ Lake County
- ☐ Larimer County
- ☐ Las Animas County
- ☐ Lincoln County
- ☐ Logan County
- ☐ Mesa County
- ☐ Mineral County
- ☐ Moffat County
- ☐ Montezuma County
- ☐ Montrose County
- ☐ Morgan County
- ☐ Otero County
- ☐ Ouray County
- ☐ Park County
- ☐ Phillips County
- ☐ Pitkin County
- ☐ Prowers County
- ☐ Pueblo County
- ☐ Rio Blanco County
- ☐ Rio Grande County
- ☐ Routt County
- ☐ Saguache County
- ☐ San Juan County
- ☐ San Miguel County
- ☐ Sedgwick County
- ☐ Summit County
- ☐ Teller County
- ☐ Washington County
- ☐ Weld County
- ☐ Yuma County

Question 2: Please indicate the type of community you work in:

- O Urban or suburban area
- O Rural area
- O Frontier area

Question 3: In working in the field of domestic violence, which one best characterizes your type of work.

- O County Probation
- O Private probation
- O State probation
- O Approved DV Treatment Provider
- O District Attorney
- O Judge
- O Public Defender
- O Private Attorney

- Police Department
- County Social Services
- Department of Corrections
- Victim Advocate for DV Treatment Provider
- Community Based Victim Services Program

Treatment Provider Questions

Question 4: *Are you currently approved by the DVOMB as a listed provider?*

- Yes
- No

Question 5: *How long have you worked with the domestic violence offender population?*

- Open ended numerical response.

Question 6: *Do you work for multiple agencies?*

- Yes
- No

Question 7: *In the last 12 months, what is the approximate number of clients who received any treatment in your program?*

Open ended numerical response.

Question 8: *Overall, to what extent do you believe the 2010 Revised DV Standards have been implemented in your program?*

- Full implementation
- Partial implementation
- No implementation
- Do not know

Question 9: *To what degree have you implemented the Domestic Violence Risk and Needs Assessment (DVRNA) tool for evaluating offender risk? For example, are all offenders receiving a DVRNA assessment prior to the start of treatment.*

- Full implementation
- Partial implementation
- No implementation
- Do not know

Question 10: *How often do you incorporate an offender's risk and needs identified from the DVRNA into their treatment plan?*

- Always
- Most of the time
- Usually

- O Sometimes
- O Never
- O N/A - Does not apply to me

Question 11: *What external sources of information do you gather for scoring the DVRNA? (PLEASE CHECK ALL THAT APPLY)*

- ☐ Substance Abuse Risk Assessment
- ☐ Mental Health Assessment
- ☐ DVSI
- ☐ Social Services
- ☐ Probation
- ☐ Police Reports
- ☐ Criminal History
- ☐ Offender Interview (e.g. self-disclosure)
- ☐ Victim Impact Statement
- ☐ Pre-Sentence Investigation
- ☐ Other (please specify)

Question 12: *Please check each additional Domestic Violence risk assessment instrument that is used on a consistent basis in your program. (PLEASE CHECK ALL THAT APPLY)*

- ☐ SARA
- ☐ DVSI
- ☐ B-SAFER
- ☐ ODARA
- ☐ DVRAG
- ☐ DVI
- ☐ Other (please specify)

Question 13: *When do you complete an offender's initial evaluation?*

- O *At in-take*
- O *Before treatment starts*
- O *After treatment begins*

Question 14: *As a clinician, do you ever have reservations using the manual override in the DVRNA when rating an offender's level of risk?*

- O Yes
- O No

Question 15: *In your experience as a MTT member, what are the two most important critical risk factors identified on the DVRNA? (1 being the most important and 5 being the least)*

- _ Prior domestic violence
- _ Drug or alcohol abuse
- _ Mental health issues
- _ Suicidal/homicidal ideation (within the prior 12 months)
- _ Use and/or threat of use of weapons in current/prior offense
- _ Criminal history

Question 16: *Please explain why you consider the critical risk factors you identified in question 5 to be the two most important risk factors identified by the DVRNA.*

Open ended narrative response.

Question 17: *In your experience as a MTT member, if an offender has previously committed domestic violence, should the offender ever be eligible for a reduction in their DVRNA risk level as they move through domestic violence treatment?*

- O Yes
- O No

Question 18: *As a member of a MTT, which of the following most closely resembles your experience with decision-making regarding offenders' placement in treatment?*

- O Decisions are primarily made by one of member of the team
- O Decisions are primarily made as a group

Question 19: *If decisions are primarily made by one of member of the team, please indicate who predominately makes the decision.*

- O Treatment provider
- O Probation/Parole Officer
- O Treatment Victim Advocate
- O *Other (please specify)*

Question 20: *In your experience as a MTT member, under what conditions might an offender be reassessed regarding their level of treatment?*

Open ended narrative response.

Question 21: *As a member of a MTT, which of the following most closely resembles your experience with decision-making regarding REASSESSMENT of an offender regarding their level of treatment?*

- O Decisions are primarily made by one of member of the team
- O Decisions are primarily made as a group

Question 22: *If REASSESSMENT decisions are primarily made by one of member of the team, please indicate who predominately makes the decision.*

- O Treatment provider
- O Probation/Parole Officer

- O Treatment Victim Advocate
- O *Other (please specify)*

Question 23: *What core components of the DVRNA are translated into identified treatment targets?*

Open ended narrative response.

Question 24: *How often do you discuss ongoing offender assessments with the other MTT members?*

- O Always
- O Most of the time
- O Usually
- O Sometimes
- O Never
- O N/A - Does not apply to me

Question 25: *What methods do you use to communicate ongoing information related to offender assessments with the other MTT members? (PLEASE CHECK ALL THAT APPLY)*

- ☐ Face-to-face meetings
- ☐ Email
- ☐ Over the Phone
- ☐ Text messages
- ☐ Video-conferencing (e.g. Skype, Go to Meeting, etc.)

Question 26: *To what degree have you implemented offender post-sentence treatment evaluations per Standards Section 4.0?*

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

Question 27: *How often are you conducting a pre-sentence treatment evaluation on offenders?*

- O Always
- O Most of the time
- O Usually
- O Sometimes
- O Never
- O N/A - Does not apply to me

Question 28: *If you conduct post-sentence intake evaluations, how often do you include a domestic violence risk assessment?*

- O Always
- O Most of the time

- O Usually
- O Sometimes
- O Never
- O N/A - Does not apply to me

Question 29: To what degree have you implemented different levels of treatment (A, B, C)?

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

Question 30: On average, how long do you estimate treatment is for offenders who SUCCESSFULLY complete your program? (Please indicate the number of weeks.)

Open ended numerical response.

Question 31: On average, how long do you estimate treatment is for offenders who UNSUCCESSFULLY complete your program? (Please indicate the number of weeks.)

Open ended numerical response.

Question 32: To what degree have you implemented Offender Competencies at your program?

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

Question 33: On average, what is the length of a GROUP treatment session? Please enter the average length of time in minutes for a GROUP treatment sessions.

Open ended numerical response.

Question 34: On average, how many offenders attend a GROUP treatment session? Please enter the average number of offenders who attend a GROUP treatment session.

Open ended numerical response.

Question 35: What type of groups does your program use?

- O Open (rolling)
- O Closed
- O Both
- O None, do not use groups

Question 36: What is the average length of an INDIVIDUAL treatment session? Please enter the average length of time in minutes for a INDIVIDUAL treatment sessions.

Open ended numerical response.

Question 37: *Given sliding scales for service fees, what is the range you charge for Group Treatment Sessions, Individual Treatment Sessions, and Offender Evaluations?*

Open ended numerical response.

Question 38: *To the best of your knowledge, to what degree have Treatment Plan Reviews been implemented in your community?*

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

Question 39: *To the best of your knowledge, are providers in your community conducting Treatment Plan Reviews every 2-3 months?*

- O Yes
- O No

Question 40: *Please check each item that is a component of your treatment program. (PLEASE CHECK ALL THAT APPLY)*

- ☐ Anger management
- ☐ Art therapies
- ☐ Attachment issues
- ☐ Attitudes that condone violent behavior
- ☐ Client's victimization/trauma
- ☐ Cognitive Behavioral Therapy
- ☐ Cognitive Restructuring Therapy
- ☐ Conflict Resolution
- ☐ Dialectical behavioral therapies
- ☐ Drama therapy
- ☐ EMDR
- ☐ Emotional regulation
- ☐ Family reunification
- ☐ Intimacy/relationship skills
- ☐ Motivational Interviewing
- ☐ Offender development of victim empathy
- ☐ Offender responsibility and acceptability
- ☐ Problem solving training
- ☐ Relapse prevention
- ☐ Schema therapy
- ☐ Self-monitoring training

- ☐ Stages of change
- ☐ Social skills training
- ☐ Therapeutic community
- ☐ Trauma therapy
- ☐ Victim awareness and empathy
- ☐ Victim clarification

Question 41: *About what percentage (on average) of clients who begin the program complete the program? Please estimate these percentages based upon the risk level at discharge.*

Open ended numerical response.

Question 42: *Does your program offer gender specific domestic violence treatment and gender specific groups?*

- O Yes
- O No

Question 43: *To the best of your knowledge, to what degree has a Multi-disciplinary Treatment Team (MTT) been implemented in your community?*

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

Question 44: *Who is regularly a part of the MTT staff meetings? (PLEASE CHECK ALL THAT APPLY)*

- ☐ Treatment Provider
- ☐ Supervising Officer
- ☐ Treatment Victim Advocate
- ☐ Victim Advocate Other
- ☐ Child Protective Services
- ☐ Substance Abuse Provider
- ☐ Mental Health Provider
- ☐ Other (please specify)

Question 45: *How often do MTT members meet (whether face-to-face or by other methods)?*

- O Never
- O Once a year
- O Once every 3 months
- O Once a month
- O About twice a month

- Once every week
- Twice a week
- Once every Day

Question 46: How often are MTT's not able to reach consensus?

- Always
- Most of the time
- Usually
- Sometimes
- Never
- N/A - Does not apply to me

Question 47: Does your program have a Treatment Victim Advocate?

- Yes
- No

Question 48: Are MTT members careful to keep victim information confidential from the offender?

- Yes
- No
- Not Sure

Question 49: How often does your Treatment Victim Advocate participate in the MTT?

- Always
- Most of the time
- Usually
- Sometimes
- Never
- N/A - Does not apply to me

Question 50: How many hours of training does the Treatment Victim Advocate at your program have in advocacy?

Open ended numerical response.

Question 51: How is your Treatment Victim Advocate funded?

- Contracts
- Memorandum of Understanding (MOU)
- Offender Fees
- Grants
- Other (please specify)

Question 52: *What are the challenges to obtaining a Treatment Victim Advocate?*

Open ended narrative response.

Question 53: *What has been your experience with a Treatment Victim Advocate being a part of the MTT?*

Open ended narrative response.

Question 54: *Please comment on the challenges that you have encountered when implementing the Revised DV Standards in your community.*

Open ended narrative response.

Question 55: *Please comment on the benefits that you have observed when implementing the DV Revised Standards in your community.*

Open ended narrative response.

Other Stakeholders

Question 56: *How long have you worked in your field related domestic violence?*

Open ended numerical response.

Question 57: *Overall, to what extent do you believe the 2010 Revised DV Standards have been implemented in your community?*

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

Question 58: *To what degree has your community implemented the Domestic Violence Risk and Needs Assessment (DVRNA) tool for evaluating offender risk? For example, are all offenders receiving a DVRNA assessment prior to the start of treatment.*

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

Question 59: *In your experience as a MTT member, what are the two most important critical risk factors identified on the DVRNA? (1 being the most important and 5 being the least important)*

- _ Prior domestic violence
- _ Drug or alcohol abuse
- _ Mental health issues
- _ Suicidal/homicidal ideation (within the prior 12 months)
- _ Use and/or threat of use of weapons in current/prior offense
- _ Criminal history

Question 60: *Please explain why you consider the critical risk factors you identified in question 5 to be the two most important risk factors identified by the DVRNA.*

Open ended narrative response.

Question 61: *In your experience as a MTT member, if an offender has previously committed domestic violence, should the offender ever be eligible for a reduction in their DVRNA risk level as they move through domestic violence treatment?*

- O Yes
- O No

Question 62: *As a member of a MTT, which of the following most closely resembles your experience with decision-making regarding offenders' placement in treatment?*

- O Decisions are primarily made by one of member of the team
- O Decisions are primarily made as a group

Question 63: *If decisions are primarily made by one of member of the team, please indicate who predominately makes the decision.*

- O Treatment provider
- O Probation/Parole Officer
- O Treatment Victim Advocate
- O *Other (please specify)*

Question 64: *In your experience as a MTT member, under what conditions might an offender be reassessed regarding their level of treatment?*

Open ended narrative response.

Question 65: *As a member of a MTT, which of the following most closely resembles your experience with decision-making regarding reassessment of an offender regarding their level of treatment?*

- O Decisions are primarily made by one of member of the team
- O Decisions are primarily made as a group

Question 66: *If reassessment decisions are primarily made by one of member of the team, please indicate who predominately makes the decision.*

- O Treatment provider
- O Probation/Parole Officer
- O Treatment Victim Advocate
- O *Other (please specify)*

Question 67: *How often do you receive information from the treatment provider regarding an offender's treatment plan?*

- O Always
- O Most of the time

- O Usually
- O Sometimes
- O Never
- O N/A - Does not apply to me

Question 68: How often do you discuss ongoing offender assessments with the other MTT members?

- O Always
- O Most of the time
- O Usually
- O Sometimes
- O Never
- O N/A - Does not apply to me

Question 69: What methods do you use to communicate ongoing information related to an offender with members of the MTT? (PLEASE CHECK ALL THAT APPLY)

- ☐ Face-to-face meetings
- ☐ Email
- ☐ Over the Phone
- ☐ Text messages
- ☐ Video-conferencing (e.g. Skype, Go to Meeting, etc.)

Question 70: To what degree has your community implemented offender post-sentence treatment evaluations per Standards Section 4.0?

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

Question 71: How often are full pre-sentence treatment evaluation on offenders being conducted in your community?

- O Always
- O Most of the time
- O Usually
- O Sometimes
- O Never
- O N/A - Does not apply to me

Question 72: *In your community, how often are domestic violence risk assessments included in post-sentence intake evaluations?*

- O Always
- O Most of the time
- O Usually
- O Sometimes
- O Never
- O N/A - Does not apply to me

Question 73: *To what degree have different levels of treatment (A, B, C) been implemented in your community?*

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

Question 74: *To what degree have Offender Competencies been implemented in your community?*

- O Full implementation
- O Partial implementation
- O No implementation
- O Do not know

APPENDIX F – Provider Implementation Survey Findings

Question 1

Which county do you work in? County	Percent (%)	Count (n)
Adams County	11.8%	17
Alamosa County	1.4%	2
Arapahoe County	18.1%	26
Archuleta County	0.7%	1
Baca County	0.7%	1
Bent County	1.4%	2
Boulder County	8.3%	12
City & County of Broomfield	1.4%	2
Chaffee County	0.0%	0
Cheyenne County	0.7%	1
Clear Creek County	2.8%	4
Conejos County	0.0%	0
Costilla County	0.0%	0
Crowley County	0.7%	1
Custer County	0.0%	0
Delta County	0.7%	1
City and County of Denver	31.9%	46
Dolores County	0.0%	0
Douglas County	9.7%	14
Eagle County	2.1%	3
Elbert County	1.4%	2
El Paso County	3.5%	5
Fremont County	2.1%	3
Garfield County	0.7%	1
Gilpin County	0.0%	0
Grand County	0.0%	0
Gunnison County	0.0%	0
Hinsdale County	0.0%	0
Huerfano County	0.0%	0
Jackson County	0.7%	1
Jefferson County	11.8%	17
Kiowa County	2.1%	3
Kit Carson County	0.7%	1
La Plata County	0.7%	1
Lake County	0.7%	1
Larimer County	6.9%	10
Las Animas County	0.0%	0
Lincoln County	0.0%	0
Logan County	1.4%	2
Mesa County	4.2%	6
Mineral County	0.0%	0
Moffat County	0.0%	0
Montezuma County	0.0%	0
Montrose County	0.7%	1
Morgan County	1.4%	2

Otero County	1.4%	2
Ouray County	0.0%	0
Park County	0.0%	0
Phillips County	0.7%	1
Pitkin County	0.0%	0
Prowers County	0.7%	1
Pueblo County	6.3%	9
Rio Blanco County	0.0%	0
Rio Grande County	0.0%	0
Routt County	0.0%	0
Saguache County	0.0%	0
San Juan County	0.0%	0
San Miguel County	0.0%	0
Sedgwick County	0.7%	1
Summit County	3.5%	5
Teller County	0.0%	0
Washington County	0.0%	0
Weld County	4.9%	7
Yuma County	0.7%	1
Total		**144**

Note: Four respondents skipped this question.

Question 2

Please indicate the type of community you work in:

	Percent	Count
Urban or suburban area	72.6%	106
Rural area	24.0%	35
Frontier area	3.4%	5
Total	**100.0%**	**146**

Note: Two respondents skipped this question.

Question 3

In working in the field of domestic violence, which one best characterizes your type of work.

	Percent	Count
Approved DV Treatment Provider	40.4%	59
State probation	28.8%	42
County Probation	21.2%	31
Private probation	0.7%	1
Victim Advocate for DV Treatment Provider	8.2%	12
District Attorney	0.0%	0
Judge	0.0%	0
Public Defender	0.0%	0
Private Attorney	0.0%	0
Police Department	0.0%	0
County Social Services	0.0%	0
Department of Corrections	0.0%	0
Community Based Victim Services Program	0.7%	1
Other (please specify)		4
Total	**100.0%**	**146**

Note: Two participants skipped this question.

Treatment Provider Questions

Question 4

Are you currently approved by the DVOMB as a listed provider?

	Percent	Count
Yes	100.0%	59
No	0.0%	0
Total	100.0%	59

Question 5

How long have you worked with the domestic violence offender population?

	Statistics
n	59
Minimum	1
Maximum	38
Median	15
Average	14.2
Standard Deviation	9.3

Question 6

Do you work for multiple agencies?

	Percent	Count
Yes	22.4%	13
No	77.6%	45
Total	**100.0%**	**58**

Notes: One respondent skipped this question.

Question 7

In the last 12 months, what is the approximate number of clients who received any treatment in your program?

	Statistics
n	57
Minimum	4
Maximum	400
Median	112.1
Average	77.5
Standard Deviation	98.6

Notes: Two respondents skipped this question.

Question 8

Overall, to what extent do you believe the 2010 Revised DV Standards have been implemented in your program?

	Percent	Count
Full implementation	87.7%	50
Partial implementation	10.5%	6
No implementation	0.0%	0
Do not know	1.8%	1
Total	**100.0%**	**57**

Notes: Two respondents skipped this question.

Question 9

To what degree have you implemented the Domestic Violence Risk and Needs Assessment (DVRNA) tool for evaluating offender risk? For example, are all offenders receiving a DVRNA assessment prior to the start of treatment.

	Percent	Count
Full implementation	94.7%	54
Partial implementation	3.5%	2
No implementation	1.8%	1
Do not know	0.0%	0
Total	**100.0%**	**57**

Notes: Two respondents skipped this question.

Question 10

How often do you incorporate an offender's risk and needs identified from the DVRNA into their treatment plan?

	Percent	Count
Always	84.2%	48
Most of the time	15.8%	9
Usually	0.0%	0
Sometimes	0.0%	0
Never	0.0%	0
N/A - Does not apply to me	0.0%	0
Total	**100.0%**	**57**

Notes: Two respondents skipped this question.

Question 11

What external sources of information do you gather for scoring the DVRNA?

	Percent	Count
Police Reports	100.0%	57
Criminal History	100.0%	57
Offender Interview (e.g. self-disclosure)	98.2%	56
Probation	93.0%	53
Victim Impact Statement	91.2%	52
Substance Abuse Risk Assessment	91.2%	52
Mental Health Assessment	78.9%	45
Pre-Sentence Investigation	64.9%	37
DVSI	63.2%	36
Social Services	61.4%	35
Other (please specify)	26.3%	15
Total		**57**

Notes: Two respondents skipped this question.

Question 12

Please check each additional Domestic Violence risk assessment instrument that is used on a consistent basis in your program. (PLEASE CHECK ALL THAT APPLY)

	Percent	Count
SARA	98.2%	54
DVSI	40.0%	22
B-SAFER	0.0%	0
ODARA	0.0%	0

DVRAG	0.0%	0
DVI	10.9%	6
Other (please specify)	29.1%	16
Total		**55**

Notes: Three respondents skipped this question.

Question 13

When do you complete an offender's initial evaluation?

	Percent	Count
At in-take	42.6%	23
Before treatment starts	35.2%	19
After treatment begins	22.2%	12
Total	**100.0%**	**54**

Notes: Five respondents skipped this question.

Question 14

As a clinician, do you ever have reservations using the manual override in the DVRNA when rating an offender's level of risk?

	Percent	Count
Yes	19.6%	10
No	80.4%	41
Total	**100.0%**	**51**

Notes: Eight respondents skipped this question.

Question 15

In your experience as a MTT member, what are the two most important critical risk factors identified on the DVRNA? (1 being the most important and 5 being the least)

	1	2	3	4	5	6	Rating Average	Count
Prior domestic violence	35	7	6	4	1	1	1.74	54
Use and/or threat of use of weapons in current/prior offense	13	16	4	7	12	1	2.85	53
Suicidal/homicidal ideation (within the prior 12 months)	3	11	13	14	3	8	3.52	52
Drug or alcohol abuse	1	15	9	8	15	4	3.63	52
Mental health issues	2	1	16	10	9	14	4.25	52
Criminal history	0	4	4	9	12	24	4.91	53
Total								**54**

Notes: Five respondents skipped this question.

Question 16

Please explain why you consider the critical risk factors you identified in question 5 to be the two most important risk factors identified by the DVRNA.

Themes – Respondents noted that critical risk factors include the following:

- Prior domestic violence is indicative of anti-sociality and potential patterns of specialization
- Weapons and alcohol increase the lethality potential
- Looking for any pattern of behavior that would present an increase in risk and danger to the victim

- Correlational research that empirically demonstrates factor as a risk

Question 17

In your experience as a MTT member, if an offender has previously committed domestic violence, should the offender ever be eligible for a reduction in their DVRNA risk level as they move through domestic violence treatment?

	Percent	Count
Yes	66.0%	35
No	34.0%	18
Total	**100.0%**	53

Note: Six respondents skipped this question.

If yes, in your experience as a MTT member, under what conditions should an offender who has committed prior domestic violence be eligible for a reduction in their DVRNA risk level?

Themes

- Demonstration of gained competencies
- Engagement and progress in treatment through the demonstration of behavior
- Victim supportive of the reduction
- Offender presents positive change and takes accountability

Question 18

As a member of a MTT, which of the following most closely resembles your experience with decision-making regarding offenders' placement in treatment?

	Percent	Count
Decisions are primarily made by one member of the team	48.2%	26
Decisions are primarily made as a group	51.8%	28
Total	**100.0%**	**54**

Notes: Five respondents skipped this question.

Question 19

If decisions are primarily made by one of member of the team, please indicate who predominately makes the decision.

	Percent	Count
Treatment provider	58.8%	20
Probation/Parole Officer	11.8%	4
Treatment Victim Advocate	2.9%	1
Other (please specify)	26.5%	9
Total	**100.0%**	**34**

Notes: 25 respondents skipped this question.

Question 20

In your experience as a MTT member, under what conditions might an offender be reassessed regarding their level of treatment?

Themes:

- Some type of recidivating event (e.g., re-offense or new charge)
- Emerging changes to dynamic risk factors (both increasing or decreasing risk)
- Satisfactory and sustained progress in treatment, learned and demonstrated competencies
- Compliance with the terms and conditions of supervision

Question 21

As a member of a MTT, which of the following most closely resembles your experience with decision-making regarding REASSESSMENT of an offender regarding their level of treatment?

	Percent	Response
Decisions are primarily made by one of member of the team	21.2%	11
Decisions are primarily made as a group	78.8%	41
Total	**100.0%**	**52**

Notes: Seven respondents skipped this question.

Question 22

If REASSESSMENT decisions are primarily made by one of member of the team, please indicate who predominately makes the decision.

	Percent	Count
Treatment provider	52.4%	11
Probation/Parole Officer	19.0%	4
Treatment Victim Advocate	0.0%	0
Other (please specify)	28.6%	6
Total	**100.0%**	**21**

Notes: 38 respondents skipped this question.

Question 23

What core components of the DVRNA are translated into identified treatment targets?

Themes:

- Each of the DVRNA components
- Mental health
- Attitudes, behaviors and risk factor components
- Intergenerational abuse and recognition of cycle

Question 24

How often do you discuss ongoing offender assessments with the other MTT members?

	Percent	Count
Always	45.3%	24
Most of the time	34.0%	18
Usually	13.2%	7
Sometimes	7.5%	4
Never	0.0%	0

N/A - Does not apply to me	0.0%	0
Total	**100.0%**	**53**

Note: Six respondents skipped this question.

Question 25

What methods do you use to communicate ongoing information related to offender assessments with the other MTT members? (PLEASE CHECK ALL THAT APPLY)

	Percent	Count
Face-to-face meetings	73.6%	39
Email	88.7%	47
Over the Phone	92.5%	49
Text messages	9.4%	5
Video-conferencing (e.g. Skype, Go to Meeting, etc.)	1.9%	1
Other (please specify)		7
Total		**53**

Note: Six respondents skipped this question.

Question 26

To what degree have you implemented offender post-sentence treatment evaluations per Standards Section 4.0?

	Percent	Count
Full implementation	84.3%	43
Partial implementation	9.8%	5
No implementation	3.9%	2
Do not know	2.0%	1
Total	**100.0%**	**53**

Notes: Six respondents skipped this question.

Question 27

How often are you conducting a pre-sentence treatment evaluation on offenders?

	Percent	Count
Always	2.0%	1
Most of the time	3.9%	2
Usually	0.0%	0
Sometimes	52.9%	27
Never	35.3%	18
N/A - Does not apply to me	5.9%	3
Total	**100.0%**	**53**

Note: Six respondents skipped this question.

Question 28

If you conduct post-sentence intake evaluations, how often do you include a domestic violence risk assessment?

	Percent	Count
Always	90.0%	45
Most of the time	4.0%	2
Usually	0.0%	0
Sometimes	0.0%	0
Never	4.0%	2
N/A - Does not apply to me	2.0%	1

Total	**100.0%**	**50**

Note: Nine respondents skipped this question.

Question 29

To what degree have you implemented different levels of treatment (A, B, C)?

	Percent	Count
Full implementation	92.2%	47
Partial implementation	7.8%	4
No implementation	0.0%	0
Do not know	0.0%	0
Total	**100.0%**	**51**

Notes: Eight respondents skipped this question.

Question 30

On average, how long do you estimate treatment is for offenders who SUCCESSFULLY complete your program? (Please indicate the number of weeks.)

	Statistics		
	Level A	Level B	Level C
n	50	52	51
Minimum	10	24	24
Maximum	36	48.5	72
Median	23.3	33.0	36.0
Average	22.4	33.0	38.5
Standard Deviation	5.1	5.5	7.9

Notes: Nine, seven and eight respondents skipped the Level A, Level B, and Level C portion of this question respectively. Some respondents reported not have enough Level A offenders to respond to indicated their relative rate of successful completion.

Question 31

On average, how long do you estimate treatment is for offenders who UNSUCCESSFULLY complete your program? (Please indicate the number of weeks.)

	Statistics		
	Level A	Level B	Level C
N	38	44	43
Minimum	0	0	0
Maximum	40	45	55
Median	6.0	10.0	10.0
Average	9.4	13.9	15.6
Standard Deviation	10.2	10.7	13.7

Notes: 21, 15 and 16 respondents skipped the Level A, Level B, and Level C portion of this question respectively.

Question 32

To what degree have you implemented Offender Competencies at your program?

	Percent	Count
Full implementation	94.2%	49
Partial implementation	3.8%	2
No implementation	0.0%	0
Do not know	1.9%	1
Total	**100.0%**	**52**

Notes: Seven respondents skipped this question.

Question 33

On average, what is the length of a GROUP treatment session? Please enter the average length of time in minutes for a GROUP treatment sessions.

	Statistics
N	52
Minimum	60
Maximum	120
Median	90
Average	90.3
Standard Deviation	6.1

Notes: Seven respondents skipped this question.

Question 34

On average, how many offenders attend a GROUP treatment session? Please enter the average number of offenders who attend a GROUP treatment session.

	Statistics
n	51
Minimum	1
Maximum	12
Median	10
Average	9.0
Standard Deviation	2.6

Notes: Eight respondents skipped this question.

Question 35

What type of groups does your program use?

	Percent	Count
Open (rolling)	94.2%	49
Closed	0.0%	0
Both	5.8%	3
None, do not use groups	0.0%	0
Total	**100.0%**	**52**

Note: Seven respondents skipped this question.

Question 36

What is the average length of an INDIVIDUAL treatment session? Please enter the average length of time in minutes for a INDIVIDUAL treatment sessions.

	Statistics
n	52
Minimum	30
Maximum	60
Median	60
Average	55.8
Standard Deviation	6.9

Note: Seven respondents skipped this question.

Question 37

Given sliding scales for service fees, what is the range you charge for:

Statistics	Group Treatment Session	Individual Treatment Session	Offender Evaluation
n	52	51	50
Minimum	$17.50	$15.00	$0.00
Maximum	$42.50	$130.00	$300.00
Median	$25.00	$50.00	$110.00
Average	$27.61	$53.26	$119.07
Standard Deviation	$6.11	$20.73	$67.16

Note: Given that providers commonly use a sliding scale fee structure, respondents gave price ranges. The average of the ranges were computed to calculate the figures above. Additionally, fee structures varied by jurisdiction. Seven individuals did not responded to the group treatment portion of the question. Eight individuals did not respond to the individual treatment portion of the question. Nine individuals did not respond to the offender evaluation portion of the question.

Question 38

To the best of your knowledge, to what degree have Treatment Plan Reviews been implemented in your community?

	Percent	Count
Full implementation	65.4%	34
Partial implementation	26.9%	14
No implementation	3.8%	2
Do not know	3.8%	2
Total	**100.0%**	**52**

Notes: Seven respondents skipped this question.

Question 39

To the best of your knowledge, are providers in your community conducting Treatment Plan Reviews every 2-3 months?

	Percent	Count
Yes	86.0%	43
No	14.0%	7
Total	**100.0%**	**50**

Notes: Nine respondents skipped this question.

Question 40

Please check each item that is a component of your treatment program. (PLEASE CHECK ALL THAT APPLY)

	Percent	Count
Offender responsibility and acceptability	98.1%	51
Cognitive Behavioral Therapy	96.2%	50
Conflict Resolution	96.2%	50
Offender development of victim empathy	94.2%	49
Relapse prevention	94.2%	49
Motivational Interviewing	90.4%	47
Problem solving training	90.4%	47
Anger management	90.4%	47
Intimacy/relationship skills	84.6%	44

Attitudes that condone violent behavior	82.7%	43
Victim awareness and empathy	84.6%	44
Stages of change	82.7%	43
Client's victimization/trauma	80.8%	42
Social skills training	76.9%	40
Cognitive Restructuring Therapy	65.4%	34
Trauma therapy	63.5%	33
Dialectical behavioral therapies	55.8%	29
Emotional regulation	69.2%	36
Attachment issues	63.5%	33
Self-monitoring training	50.0%	26
Victim clarification	42.3%	22
EMDR	32.7%	17
Family reunification	17.3%	9
Therapeutic community	15.4%	8
Schema therapy	7.7%	4
Drama therapy	1.9%	1
Art therapies	0.0%	0
Other (please specify)		11
Total		**52**

Note: Seven respondents skipped this question.

Question 41

About what percentage (on average) of clients who begin the program complete the program? Please estimate these percentages based upon the risk level at discharge.

	Statistics		
	Level A	**Level B**	**Level C**
N	46	49	48
Minimum	0%	50%	20%
Maximum	100%	100%	100%
Median	98.5%	85%	80%
Average	88.7%	84.3%	78.9%
Standard Deviation	23.5%	12.3%	16.1%

Notes: 13, 10 and 11 respondents skipped the Level A, Level B, and Level C portion of this question respectively.

Question 42

Does your program offer gender specific domestic violence treatment and gender specific groups?

	Percent	**Count**
Yes	92.3%	48
No	7.7%	4
Total	**100.0%**	**52**

Notes: Skipped question 96

Question 43

To the best of your knowledge, to what degree has a Multi-disciplinary Treatment Team (MTT) been implemented in your community?

	Percent	**Count**
Full implementation	62.7%	32
Partial implementation	29.4%	15
No implementation	2.0%	1

Do not know	5.9%	3
Total	**100.0%**	**51**

Note: Eight respondents skipped this question.

Question 44

Who is regularly a part of the MTT staff meetings? (PLEASE CHECK ALL THAT APPLY)	**Percent**	**Count**
Treatment Provider	98.0%	50
Supervising Officer	88.2%	45
Treatment Victim Advocate	74.5%	38
Substance Abuse Provider	54.9%	28
Mental Health Provider	39.2%	20
Child Protective Services	21.6%	11
Victim Advocate Other	13.7%	7
Other (please specify)	21.6%	11
Total	**100.0%**	**51**

Note: Eight respondents skipped this question.

Question 45

How often do MTT members meet (whether face-to-face or by other methods)?	**Percent**	**Count**
Never	0.0%	0
Once a year	2.0%	1
Once every 3 months	35.3%	18
Once a month	45.1%	23
About twice a month	13.7%	7
Once every week	3.9%	2
Twice a week	0.0%	0
Once every Day	0.0%	0
Total	**100.0%**	**51**

Note: Eight respondents skipped this question.

Question 46

How often are MTT's not able to reach consensus?	**Percent**	**Count**
Always	12.0%	6
Most of the time	8.0%	4
Usually	2.0%	1
Sometimes	36.0%	18
Never	42.0%	21
N/A - Does not apply to me	0.0%	0
Total	**100.0%**	**50**

Notes: Nine respondents skipped this question.

Question 47

Does your program have a Treatment Victim Advocate?	**Percent**	**Count**
Yes	100.0%	50
No	0.0%	0
Total	**100.0%**	**50**

Notes: Nine respondents skipped this question.

Question 48

Are MTT members careful to keep victim information confidential from the offender?

	Percent	Count
Yes	100.0%	51
No	0.0%	0
Not Sure	0.0%	0
Total	**100.0%**	**51**

Notes: Eight respondents skipped this question.

Question 49

How often does your Treatment Victim Advocate participate in the MTT?

	Percent	Count
Always	39.2%	20
Most of the time	35.3%	18
Usually	5.9%	3
Sometimes	15.7%	8
Never	3.9%	2
N/A - Does not apply to me	0.0%	0
Total	**100.0%**	**51**

Notes: Eight respondents skipped this question.

Question 50

How many hours of training does the Treatment Victim Advocate at your program have in advocacy?

	Statistics
N	46
Minimum	14
Maximum	1000
Median	37.5
Average	115.8
Standard Deviation	272.9

Notes: 13 respondents skipped this question.

Question 51

How is your Treatment Victim Advocate funded?

	Percent	Count
Contracts	16.1%	9
Employee	21.4%	12
Memorandum of Understanding (MOU)	12.5%	7
Offender Fees	19.6%	11
Grants	5.4%	3
Other (please specify)	25.0%	14
Total	**100.0%**	**56**

Notes: Three respondents skipped this question.

Question 52
What are the challenges to obtaining a Treatment Victim Advocate?

Themes:

- Some reported no challenges at this time
- Availability and expertise of treatment victim advocates is limited
- Financial costs associated with hours, salary and liability issues were reported as challenges
- Training opportunities for victim advocates

Question 53
What has been your experience with a Treatment Victim Advocate being a part of the MTT?

Themes:

- Majority respondents indicated positive experiences working with treatment victim advocates. These experiences generally characterized as insightful, important and beneficial.
- Some respondents indicated that their experience working with a treatment victim advocate was mixed or poor. Criticisms included not being able to share information, scheduling issues and a lack of overall participation.

Question 54
Please comment on the challenges that you have encountered when implementing the Revised DV Standards in your community.

Themes:

- Not sufficient amount of Level A offenders to justify a stand-alone group
- Challenges with Probation include resistance, misinterpretation of the Standards and variability between districts
- Enrolling offenders in second clinical contact
- Limitations of the DVRNA
- Evaluating risk for special populations (i.e., females, Hispanics, etc.)
- Financial costs of market-based system

Question 55
Please comment on the benefits that you have observed when implementing the DV Revised Standards in your community.

Themes:

- Increased communication and collaboration in the community
- Differential treatment options for lower risk offenders
- Raising the quality, individualization and comprehensiveness of treatment
- DVRNA and offender competencies provides a framework for treatment
- Clients appear to have better outcomes with current system as opposed to the old Standards

Stakeholders Other Than Treatment Providers (i.e., MTT Members such as Probation)

Question 56

How long have you worked in your field related domestic violence?

	Statistics
N	81
Minimum	0.7
Maximum	25
Median	6.5
Average	7.6
Standard Deviation	6.0

Note: Six participants skipped this question.

Question 57

Overall, to what extent do you believe the 2010 Revised DV Standards have been implemented in your community?

	Percent	Count
Full implementation	50.0%	42
Partial implementation	42.9%	36
No implementation	0.0%	0
Do not know	7.1%	6
Total	**100.0%**	**84**

Note: Three participants skipped this question.

Question 58

To what degree has your community implemented the Domestic Violence Risk and Needs Assessment (DVRNA) tool for evaluating offender risk? For example, are all offenders receiving a DVRNA assessment prior to the start of treatment?

	Percent	Count
Full implementation	72.6%	61
Partial implementation	15.5%	13
No implementation	1.2%	1
Do not know	10.7%	9
Total	**100.0%**	**84**

Note: Three participants skipped this question.

Question 59

In your experience as a MTT member, what are the two most important critical risk factors identified on the DVRNA? (1 being the most important and 5 being the least)

	1	2	3	4	5	6	Rating Average	Response Count
Prior domestic violence	42	14	12	9	6	0	1.74	83
Use and/or threat of use of weapons in current/prior offense	17	21	19	9	11	6	2.85	83
Suicidal/homicidal ideation (within the prior 12 months)	17	14	15	6	19	11	3.52	82
Drug or alcohol abuse	4	14	22	23	17	3	3.63	83
Mental health issues	2	11	10	27	22	11	4.25	83
Criminal history	1	9	5	9	8	51	4.91	83
Total								**83**

Notes: Four participants skipped this question.

Question 60

Please explain why you consider the critical risk factors you identified in question 5 to be the two most important risk factors identified by the DVRNA.

Themes – Respondents noted that critical risk factors include the following:

- Prior domestic violence offenses represents significant risk factor
- Suicidal or homicidal ideation
- Weapons and threats increase the lethality potential
- Drug and alcohol abuse, mental health factors

Question 61

In your experience as a MTT member, if an offender has previously committed domestic violence, should the offender ever be eligible for a reduction in their DVRNA risk level as they move through domestic violence treatment?

	Percent	Count
Yes	61.0%	50
No	39.0%	32
Total	**100.0%**	**82**

Notes: Five participants skipped this question.

Question 62

As a member of a MTT, which of the following most closely resembles your experience with decision-making regarding offenders' placement in treatment?

	Percent	Count
Decisions are primarily made by one member of the team	37.4%	31
Decisions are primarily made as a group	62.6%	52
Total	**100.0%**	**83**

Notes: Four participants skipped this question.

Question 63

If decisions are primarily made by one of member of the team, please indicate who predominately makes the decision.

	Percent	Count
Treatment provider	67.3%	35
Probation/Parole Officer	21.2%	11
Treatment Victim Advocate	0.0%	0
Other (please specify)	11.5%	6
Total	**100.0%**	**52**

Notes: 35 participants skipped this question.

Question 64

In your experience as a MTT member, under what conditions might an offender be reassessed regarding their level of treatment?

Themes:

- Progression of treatment, identification of new or updated risk factors, new alleged offenses

Question 65

As a member of a MTT, which of the following most closely resembles your experience with decision-making regarding reassessment of an offender regarding their level of treatment?

	Percent	Count
Decisions are primarily made by one member of the team	25.6%	21
Decisions are primarily made as a group	74.4%	61
Total	**100.0%**	**82**

Notes: Five participants skipped this question.

Question 66

If reassessment decisions are primarily made by one of member of the team, please indicate who predominately makes the decision.

	Percent	Count
Treatment provider	68.3%	28
Probation/Parole Officer	19.5%	8
Treatment Victim Advocate	0.0%	0
Other (please specify)	12.2%	5
Total	**100.0%**	**41**

Notes: 46 participants skipped this question.

Question 67

How often do you receive information from the treatment provider regarding an offender's treatment plan?

	Percent	Count
Always	19.0%	15
Most of the time	49.4%	39
Usually	15.2%	12
Sometimes	12.7%	10
Never	1.3%	1
N/A - Does not apply to me	2.5%	2
Total	**100.0%**	**79**

Note: Eight participants skipped this question.

Question 68

How often do you discuss ongoing offender assessments with the other MTT members?

	Percent	Count
Always	13.6%	11
Most of the time	42.0%	34
Usually	19.8%	16
Sometimes	19.8%	16
Never	2.5%	2
N/A - Does not apply to me	2.5%	2
Total	**100.0%**	**81**

Notes: Six participants skipped this question.

Question 69

What methods do you use to communicate ongoing information related to offender assessments with the other MTT members? (PLEASE CHECK ALL THAT APPLY)

	Percent	Count
Face-to-face meetings	74.1%	60
Email	92.6%	75
Over the Phone	91.4%	74
Text messages	8.6%	7
Video-conferencing (e.g. Skype, Go to Meeting, etc.)	0.0%	0
Other (please specify)	6.2%	5
Total		**81**

Note: Six participants skipped this question.

Question 70

To what degree has your community implemented offender post-sentence treatment evaluations per Standards Section 4.0?

	Percent	Count
Full implementation	41.3%	33
Partial implementation	15.0%	12
No implementation	2.5%	2
Do not know	41.3%	33
Total	**100.0%**	**80**

Note: Seven participants skipped this question.

Question 71

How often are full pre-sentence treatment evaluation on offenders being conducted in your community?

	Percent	Count
Always	10.7%	8
Most of the time	14.7%	11
Usually	5.3%	4
Sometimes	25.3%	19
Never	20.0%	15
N/A - Does not apply to me	24.0%	18
Total	**100.0%**	**75**

Note: 12 participants skipped this question.

Question 72

In your community, how often are domestic violence risk assessments included in post-sentence intake evaluations?

	Percent	Count
Always	51.3%	39
Most of the time	23.7%	18
Usually	9.2%	7
Sometimes	1.3%	1
Never	4.0%	3
N/A - Does not apply to me	10.5%	8
Total	**100.0%**	**50**

Note: 11 participants skipped this question.

Question 73

To what degree have different levels of treatment (A, B, C) been implemented in your community?

	Percent	Count
Full implementation	82.5%	66
Partial implementation	15.0%	12
No implementation	0.0%	0
Do not know	2.5%	2
Total	**100.0%**	**80**

Note: Seven participants skipped this question.

Question 74

To what degree have Offender Competencies been implemented in your community?

	Percent	Count
Full implementation	67.5%	54
Partial implementation	25.0%	20
No implementation	0.0%	0
Do not know	7.5%	6
Total	**100.0%**	**80**

Note: Seven participants skipped this question.

APPENDIX G – Gover, A., Richards, T. and Tomisch, E. (2015). Colorado's Innovative Response to Domestic Violence Offender Treatment: Current Achievements and Recommendations for the Future. *Buechner Institute for Governance Criminology and Criminal Justice Research Initiative*.

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