COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD

STANDARDS FOR TREATMENT WITH COURT ORDERED DOMESTIC VIOLENCE OFFENDERS

Colorado Department of Public Safety
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COLORADO
Division of Criminal Justice
Department of Public Safety

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

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

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

III. Provide overview of the findings based at a minimum on the following:

A. Domestic violence dynamics
B. Review of the DVRNA (Reference *Standard* 5.04) and one other DV risk assessment.
C. Level and nature of domestic violence risk as described in terms of scenario development (e.g., likelihood, imminence, frequency, severity, victims, and context).[5]
D. Offender accountability (Reference Appendix E, Section I)
E. Offender motivation and prognosis (Reference Appendix E, Section II)
F. Criminogenic needs (Reference Appendix E, Section IV)
G. Offender responsivity (Reference Appendix E, Section VI)
H. Specific victim safety issues

IV. Design an offender treatment plan to include at a minimum:

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

[5] J. Reid Meloy and Thomas Schroder, Violence Risk and Threat Assessment: A Practical Guide for Mental Health and Criminal Justice Professionals (San Diego, CA: Specialized Training Services, 2000).

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Appendix K: Guidelines for Young Adult Offenders Adopted February 10, 2017

I. Introduction

The purpose of this appendix is to provide Multi-Disciplinary Treatment Teams (MTTs) with additional guidance on working with domestic violence offenders ages 18-25, who can be classified as young adults (note, this population is also sometimes referred to as transitioned-aged). This informational document provides MTTs with best practices guidelines, potential risk and protective factors, and suggestions for the treatment and case management of young adults. The guidelines in this appendix do not replace any of the mandates currently required in the *Standards*. A Young Adult Committee of the DVOMB was convened to develop these Guidelines. The Committee, comprised of state and local experts in the field of at-risk youth, delinquent juveniles, and young adult populations (including treatment providers, victim service providers and advocates, probation/corrections officers, and others involved in the criminal justice system) collaborated on the creation of this Appendix. Clinical and professional expertise, as well as a review of available research and literature, served as the foundation for these Guidelines.

The Risk, Need, and Responsivity (RNR) principles are an evidence-based framework for evaluating, treating and supervising individuals involved with the criminal justice system. The RNR principles originated from numerous high-quality and generalizable studies in the broader criminological literature (Andrews & Bonta, 2010). The RNR principles state the following:

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

- Need - Interventions are most effective if services target criminogenic needs (both social and psychological factors) that have been empirically associated with recidivism; and

- Responsivity - Effective service delivery of treatment and supervision requires individualization that matches the offender's strengths, culture, learning style, and abilities, among other factors. (Please see Appendix E (VI) - Responsivity Principle and Factors).

The DVOMB recognizes that based on responsivity issues and the needs of young adults, a different approach may be needed when addressing the unique challenges of this population. Neurobiological research gives us a deeper understanding of adolescent, young adult brain development, and neuro-psychology.[1] This research indicates that the brains of young adults are more fluid, and are still developing and changing until the age of 25 (Perry, 2009; Spear, 2010, Teicher, 2002). As a result, some young adults may not recognize the consequences of their behaviors and may present more like an adolescent rather than an adult. Research indicates that over-responding to non-criminal violations with this population can cause more harm than good for the offender, victim and community (Teicher, 2002). As a result, young adults are at higher risk for dropping out of treatment (Buttell & Carney, 2008; Jewell & Wormith, 2010), therefore, it is imperative for MTT members to

[1] During adolescence, the human brain experiences increased growth, connectivity, and synaptic pruning (Spear, 2010). The rate at which the development of the neural pathways associated with regulation and reward sensitivity may provide insight into the characteristics of emerging adulthood.

assess and treat this population within a framework that is appropriate for this population.

Disclaimer of Risk and Safety Issues: The information outlined in this Appendix does not replace, change or supersede the risk factors identified by the Domestic Violence Risk and Needs Assessment (DVRNA) as part of the Offender Evaluation. These guidelines offer recommendations to lower risk and enhance responsivity by increasing treatment readiness and amenability to make positive behavioral change. Additional offender competencies are necessary to address specific issues unique to the development of the young adult population that may not be currently addressed by Standard 5.08. Appropriate interventions should be commensurate with the nature and severity of the behavior and the degree to which it relates to risk. Risk of harm to others must not be ignored and should be balanced when assessing impulsive behavior typical in adolescence versus more criminal and anti-social characteristics, which are indicative of heightened risk.

II. Guiding Principles

The Guiding Principles (described in Section 3.0) are designed to assist and guide the work of those involved in the management and containment of domestic violence offenders. For the purposes of this Appendix, the following guiding principles in the Standards may or may not be relevant or appropriate for young adult offenders.

Guiding Principle	Issue for Consideration with Young Adults
GP 3.06 - It is the nature of domestic violence offenders that their behaviors tend to be covert, deceptive, and secretive. These behaviors are often present long before they are recognized publicly.	Young adults may not have a prior history of domestic violence due to their age, and a history of delinquency may be more prevalent. Impulsivity and poor decision-making may be attributed to the index offense. As a result, deceptiveness and secrecy may not be as normative with young adults.
GP 3.13 - The preferred treatment modality is group therapy.	Research and clinical experience indicates that young adults tend to respond better to a combination of both individual and group sessions. If not, negative therapeutic outcomes may occur by exposing young adults to older adults who are higher risk and developmentally more mature (Abracen et al., 2016; Lowencamp & Latessa, 2004).
GP 3.15 - Offender treatment must address the full spectrum of abusive and controlling behaviors associated with domestic violence, and not just the legally defined criminal behavior(s).	Young adults may be at a developmental stage where maladaptive patterns of violence (with intimate partners and significant others) may not fully be present, but may or may not require an intervention that addresses the full-spectrum of abusive and controlling behaviors.

III. Young Adult Risk and Protective Factor Considerations

Given the emerging research on young adults, it is important for the MTT to evaluate an offender's problematic behavior and assess their developmental maturation. When responding to rule breaking or non-compliance, it is best to determine whether or not it signifies an increase in risk. If so, the MTT should assess what needs exist and what intervention best addresses those needs and manages risks appropriately. Such assessment should include strengths and protective factors.[2]

Contributing risk factors in young adults will likely be best mitigated by ensuring the MTT prioritizes the RNR principles and ensures all of these are assessed and addressed in treatment. The DVRNA is based on adult risk factors and does not address protective factors that may be present within young adult clients. Providers should consider research-supported developmentally-appropriate risk and protective factors in the ongoing assessment and case management of young adults (see attachment 1 for examples of potential risk and protective factors for this population). Providers should exercise clinical judgement with these cases in terms of identification of risk and protective factors, and consult with other professionals asneeded.

Risk Assessment Instruments and Collateral Information

The DVRNA instrument still applies to the young adult population. However, young adults may possess issues that require further assessment and consideration of risk and needs. Adult risk assessment instruments may or may not necessarily address the unique factors of the young adult population. After conducting a thorough evaluation, in accordance with Section 4.0 of the Standards, alternative risk assessments may be appropriate in some cases to use for juveniles under the age of 18 for informational purposes only. It is important to note that using a juvenile risk assessment instrument on an individual over the age of 18 is not a validated assessment of risk, but may be informative for case planning.

IV. Responsivity Issues Affecting Young Adults to Consider

The MTT should individualize treatment and supervision for young adults, to the extent possible, in relation to their present development, deficits and amenability to treatment. Group-specific sessions for young adults should be considered and utilized by providers (where applicable), in order to minimize the exposure of young adults to older adults who are higher risk and developmentally more mature. Additionally, it may be more appropriate for young adults to receive individual sessions instead of group sessions based on the clinical judgement of a provider. Providers utilizing individual sessions with young adults should develop treatment plans that address the client's individual needs, their Core Competencies and other unique issues present.

It is important for the MTT to also understand the characteristics of offenders that may be more likely to lead to treatment dropout. The research indicates that a client is more likely to complete treatment if they are older and employed (Buttell & Carney, 2008; Jewell & Wormith, 2010). As a result, the challenges associated with emerging adulthood such as finding stable housing, employment and relationships may increase treatment dropout for young adults. Providers should consider any healthy and pro-social factors that may assist a young adult client's initial engagement

[2] Protective factors are conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk in families and communities.

in the therapeutic process and commitment over time, and focus on development of protective factors.

V. MTT Guidelines for Decision-Making

MTTs are encouraged to assess and develop individualized treatment plans including containment efforts for young adults, based on their maturation and risk levels. Independent living skills, risk, and protective factors should be discussed by MTTs and factored into programming for the offender. MTTs should consult with other experienced adult and juvenile practitioners to assist in the development of effective treatment and supervision, and to identify possible resources that may aid in information gathering, where such experience is lacking.

Recommendations:

- Use an evidence-based, research-informed or best practice curriculum for this population (see for example, Gibbes, L. & Myers, L., 2011)
- Consider the following treatment Issues, among others:
  - Self-efficacy and self-identity
  - Empathy
  - Developmental stage
  - Appropriate boundaries and communication in relationship
  - Age appropriate healthy sexuality
  - Age appropriate healthy sexual behavior
  - Appropriate use of electronic devices and social media
  - Appropriate dating skills
  - Positive support groups and peer associations
- Consider additional core competencies, as appropriate (See Section 5.08, VI)
- Support ongoing research to better inform interventions with this population
- Stay current on research related to this population, including developmental issues
- Consult with other professionals as needed
- Participate in trainings on:
  - Human development and maturation of young adults
  - Brain development and neuro-psychology

VI. Links to Resource Documents

Gibbes, L. & Myers, L. (2011). Colorado Teen Dating Violence Prevention Final Report Primary Prevention of Teen Dating Violence in the Denver-Aurora Community: Best Practices and Strategy Recommendations. Colorado Department of Public Health and Environment.

Click Here

Oudekerk, B., Blachman-Demner, D., & Mulford, C. (2014). Teen Dating Violence: How Peers Can Affect Risk & Protective Factors. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, NCJ 248337.

Click Here

Attachment 1 - Examples of Potential Risk and Protective Factors for this Population

This table is meant to be a resource that lists some possible risk and protective factors associated with youth that may be considered for young adults. This is not exhaustive list of risk or protective factors as there may be others that should be considered by the MTT. Providers should consider research-supported developmentally-appropriate risk and protective factors in the ongoing assessment and case management of young adults. Providers should exercise clinical judgement with these cases in terms of identification of risk and protective factors, and consult with other professionals as needed.

Table of Risk and Protective Factor Chart

Domains	Risk Factors	Adolescent Problem Behaviors						Protective Factors
	Risk factors increase the likelihood youth will develop problem behaviors	Substance Use	Depression/ Anxiety	Delinquency	Teen Pregnancy	School Dropout	Violence	**Protective factors help protect or buffer the risks of youth developing problem behaviors.**
Community	Availability of alcohol/ other drugs	x					x	1. Opportunities for prosocial involvement in the community 2. Recognition of prosocial involvement
	Availability of firearms			x			x	
	Community laws and norms are favorable toward drug use, firearms and crime	x	x	x			x	
	Transitions and mobility	x		x				
	Low neighborhood attachment and community disorganization	x		x			x	
	Media portrayals of violence	x		x			x	
	Extreme economic deprivation	x		x	x	x	x	
Family	Family history of problem behavior	x	x	x	x	x	x	1. Bonding to family with healthy beliefs and clear standards 2. Attachment to family with healthy beliefs and clear standards 3. Opportunities for prosocial involvement 4. Recognition for prosocial involvement
	Family management problems	x	x	x	x	x	x	
	Family management problems	x	x	x	x	x	x	
	Family conflict	x		x	x	x	x	
	Favorable parental attitudes	x		x			x	

Table of Risk and Protective Factor Chart, continued...

Domains	Risk Factors	Adolescent Problem Behaviors						Protective Factors
	Risk factors increase the likelihood youth will develop problem behaviors	Substance Use	Depression/ Anxiety	Delinquency	Teen Pregnancy	School Dropout	Violence	**Protective factors help protect or buffer the risks of youth developing problem behaviors.**
School	Academic failure beginning in late elementary school	x		x	x	x	x	1. Bonding and attachment to school 2. Opportunities for prosocial involvement 3. Recognition for prosocial involvement
	Lack of commitment to school	x		x	x	x	x	
Individual/ Peer	Early and persistent antisocial behavior	x		x	x	x	x	1. Bonding to peers with healthy beliefs and clear standards 2. Attachment to peers with healthy beliefs and clear standards 3. Opportunities for prosocial involvement 4. Increase in social skills
	Rebelliousness	x	x	x		x		
	Friends who engage in the problem behavior	x		x	x	x	x	
	Favorable attitudes toward the problem behavior	x		x	x	x		
	Early initiation of the problem behavior	x		x	x	x	x	
	Gang involvement	x		x			x	
	Constitutional factors	x	x	x			x	

Source: Hawkins, J., Catalano, R., Arthur, M. (2002). Promoting science-based prevention in communities. *Addictive Behavior*, 27(6):951-76.

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