Welcome to Domestic Violence Offender Evaluation and Intervention Training

Presented by the Utah Association of Domestic Violence Treatment (UADVT)
January 2015

1

Overview
Who is the UADVT?

- **Mission:**
  "Advancing domestic violence treatment, increasing offender accountability and improving victim safety and recovery"
- Organized as a non-profit organization in 2013 to support treatment providers who work with people impacted by DV
- UADVT meets monthly and provides training, conferences and resources statewide

2

Overview
What is included in this training?

- 24-hours of specialized training for Treatment Providers who work with people adjudicated on charges of domestic violence in Utah (felony and misdemeanor charges)
- Instruction in providing court-ordered offender evaluation and intervention services,
- Core concepts of victim rights, trauma-informed principles, and safety planning

3

Overview
How does this training benefit you?

- Meets the requirements of Utah Administrative R501-21-5 and R501-21-6
- Satisfies the required pre-service/ongoing hours of specialized DV training annually required by the Department of Human Services Office of Licensing
- Connects you with multiple providers, tools, and concepts to enhance your practice

4

Overview
How does this training benefit you?

- Per Utah statute and Administrative R501-21-5 and R501-21-6--
- Mental health professionals licensed by DOPL and the Department of Human Services Office of Licensing, who have completed this training as pre-service or ongoing specialized DV training, are eligible to
  - Provide court ordered offender evaluation and intervention services
  - Apply for DHS DCFS contracts providing reimbursement for DV services

5

Overview
What to expect:

- 24 hours of specialized training (including homework) over three days; 8am-4pm (one hour lunch, morning and afternoon breaks)--please sign in daily
- Interactive instructions and ongoing dialogue
- Multiple experts and presenters (researchers, clinicians, detectives, victim advocates, policy makers and administrators)
- Certificate of attendance available once the online test is successfully completed, sent to you directly

6

Overview
Who will you hear from?

- **This training is provided as a cooperative effort on behalf of the UADVT, the Utah Domestic Violence Coalition, and the Department of Human Services**
- **Developed collectively through a series of focus groups with clinicians and researchers working in this field**

7

Overview
Modules included in this training:

- I-Introduction and overview of local and national DV trends
- II-Victim advocacy, safety and resources
- III-Essential elements of offender evaluation and assessment
- IV-Best practices in DV Offender intervention
- V-Review and certification

8

LET'S GET STARTED!

Module I--
Local and national DV trends

-Jenn Oxborrow, LCSW
Utah Department of Human Services
Domestic Violence Program Administrator

This Module will support your ability to:
Understand the current DV needs and trends

9

CURRENT RATES AND TRENDS OF DOMESTIC VIOLENCE IN THE US

- On average, 24 people per minute are victims of rape, physical violence, or stalking by an intimate partner in the United States.
- Over the course of a year, that equals more than 12 million women and men.
- More than 1 million women are raped in a year
- Over 6 million women and men are victims of stalking in a year. (CDC NISVS 2011)

10

ISN'T UTAH SAFER OVERALL?

- Strong family values
- Low rate of homicides compared to national averages
- Mandatory reporting laws for child welfare and vulnerable adults
- Dedicated funding to victim service programming and violence prevention

11

UTAH'S DOMESTIC VIOLENCE SERVICES CURRENT BUDGET STRUCTURE— $7 MILLION PER YEAR

- Funding for domestic violence services in the Division of Child and Family Services currently consists of:
  - State General Fund (19%)
  - Federal grants (63%)
  - Domestic Violence Services Restricted Account (18%)
- Funding is passed through on contract to service providers

12

HOW DOES THIS STATE AND FEDERAL FUNDING SUPPORT VICTIMS IN UTAH?

- Philosophy: Utah has a responsibility to ensure essential care and services are available to victims of domestic violence; offender accountability, restorative justice and recovery support victim safety
- ***Goal: Ensure an array of victim services are available throughout the state; make Mandatory Offender Treatment Accessible, Affordable and Productive***

13

HOW DOES THIS STATE AND FEDERAL FUNDING SUPPORT VICTIMS IN UTAH?

- 13 private, non=profit contracted (+ 2 DCFS owned) **victim service** providers who deliver:
  - Emergency shelter
  - Legal advocacy
  - Transitional housing support
  - Child care
  - Social and emotional support
  - Individual and group counseling
  - Connection to victim resources

$3.1 million state and federal funding per year

14

HOW DOES THIS STATE AND FEDERAL FUNDING SUPPORT VICTIMS IN UTAH?

- Over 50 DHS contracted DV behavioral healthcare professionals in Utah providing:
  - Subsidized, mandated offender evaluations (assessments)
  - Subsidized, mandated offender intervention services (group and individual)
  - Fully subsidized individual and group counseling for victims and children impacted by DV (in addition to CVR, Medicaid and private insurance coverage)

At least $3.5 million state funds per year

15

UTAH CODE OUTLINING COURT-ORDERED DV OFFENDER SERVICES

- **77-36-5** (5) The court shall order the defendant to obtain and satisfactorily complete treatment or therapy in a domestic violence treatment program, as defined in Section **62A-2-101**, ***that is licensed by the Department of Human Services, unless the court finds that there is no licensed program reasonably available or that the treatment or therapy is not necessary.***
- **62A-2-101. Definitions.** (11) "Domestic violence treatment program" means a nonresidential program designed to provide psychological treatment and educational services to perpetrators and victims of domestic violence.

16

UTAH CODE OUTLINING COURT-ORDERED DV OFFENDER SERVICES

- **R501-21-5 and R501-21-6** Individual therapists conducting domestic violence assessments and treatment services shall complete ***specialized*** training in domestic violence assessment and treatment practices as outlined below:
- Before providing treatment services therapists shall have 24 hours of pre-service training specific to domestic violence. This training shall have been completed within the last two years.
- Therapists shall obtain 16 approved CEU's (Continuing Education Units) related to domestic violence annually thereafter.
- **Treatment sessions for each perpetrator, not including orientation and assessment interviews, shall be provided for at least one hour per week for a minimum of sixteen weeks.**

17

WHAT OUTCOMES DO WE CURRENTLY SEE FROM DV SERVICES IN UTAH?

How is our $7 million investment performing?

- Utah's rate of domestic violence and sexual assault is significantly higher than the U.S. rate and has been for at least 5 years (UDVC/NNEDV/CDC)
- There are at least 3 domestic violence-related suicides every month in Utah (Utah Violent Death Reporting System, 2003-2008).
- Since 2000, domestic violence-related homicides accounted for 39.9% of all adult homicides in Utah

Source: Utah Department of Health Violence and Injury Prevention Program

18

WHAT OUTCOMES DO WE CURRENTLY SEE FROM DV SERVICES IN UTAH?

How is our $7 million investment performing?

- The number of DV victims turned away from DV shelters due to lack of beds rose from 1,677 in 2008 to 2,809 in 2012, an increase of 67%.

Utah Commission on Criminal and Juvenile Justice. No More Secrets – Utah's Domestic and Sexual Violence Report, 2012

- In SFY 2013, 221,065 Adults were in need of, and did not receive, Mental Health Services, AND
- 53,892 Children and Youth were in need of, and did not receive, Mental Health Services.

Source: Holzer, C.E. & Nguyen, H.T. Synthetic Estimates of Mental Health Needs for Utah based on SFY2013 Census Estimates from www.charles.holzer.com

19

DID YOU KNOW, DOMESTIC VIOLENCE SURVIVIORS IN UTAH

Experience **TWICE** the rate of:

- Mental illness (**29.8%** vs. 13.7%)
- Substance abuse (**9.8%** vs. 4.3%)

than women in Utah who have not experienced intimate partner violence (VIPP)

20

DID YOU KNOW, DOMESTIC VIOLENCE RELATED HOMICIDES IN UTAH . . .

Isn't Utah safer, OVERALL?

- Account for at least three DV-related homicides each month; 43% of our homicides are DV related
- And, women are 10 times more likely than males to die from domestic violence.

21

DID YOU KNOW, IN UTAH . . .

- The majority of DV homicides (67.8%) involved a firearm.
- The majority of DV homicides are committed by males.
- One-third of the domestic violence perpetrators committed suicide after committing the homicide.

Isn't Utah safer, OVERALL?

22

HOW IS UTAH'S DV RATE IMPACTING OUR COMMUNITIES?

- Domestic violence calls are the most lethal calls for law enforcement to investigate
- In the past month, two innocent bystanders were killed when DV offenders fled their homes following a DV assault
- Utah's DV Fatality Review Committee and the Governor's Office have identified recidivism trends and increased risk of lethality in repeat offenders; high cost/high risk
- High birthrate + high IPV rate = high rate of childhood exposure to IPV and associated risks

23

WHAT DO WE KNOW ABOUT THE CYCLE OF VIOLENCE?

- Studies have shown that 60% to 75% of families with intimate partner violence have children who are also maltreated (CDC Public Health Reports, July 2006).
- Being abused or neglected as a child increases the likelihood of arrest as a juvenile by 53% and of arrest for a violent crime as an adult by 38%. OJJDP, 2002

24

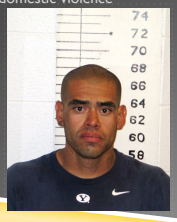
RESEARCH: WHAT DO WE KNOW ABOUT THE CYCLE OF VIOLENCE?

- Children who witness family violence are at an increased risk of entering violent relationships as teens and adults.
- ACE study documents the conversion of traumatic emotional experiences in childhood into organic disease later in life
  - ACES, Felitti and the CDC

25

THE GRAVITY OF OFFENDER EVALUATION AND TREATMENT WORK —CASE STUDY #1

William Lawton, 29, charged with domestic violence



Client History and Mandated Services:

- Adopted at birth, no known history of abuse or trauma
- Early onset mental illness and substance use disorders
- 2010-misdemeanor counts of assault and theft, family violence perpetrated against his elderly parents who continually reported escalating concerns
- DV services coordinated by DCFS, William attended mandatory, subsidized "Anger Management" per his court order and evaluation

26

THE GRAVITY OF OFFENDER EVALUATION AND TREATMENT WORK —CASE STUDY #1

William Lawton, 30, charged with aggravated murder

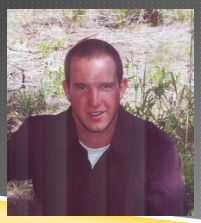
One year later . . .

- Beat and strangled his father, James Lawton, 77, an elementary school teacher with no history of violence
- With William's help, police locate his father's body
- Evaluated for competency to stand trial

27

THE GRAVITY OF OFFENDER EVALUATION AND TREATMENT WORK —CASE STUDY #2

Jacob Milchak, 24-



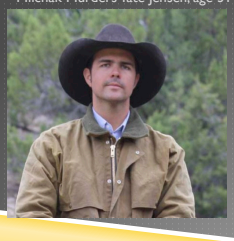
Client History and Mandated Services:

- Reported family violence history and academic, peer, employment problems for 8+ years
- 2008 –Misdemeanor substance-related charges
- 2009-10– Misdemeanor Domestic Violence Charges; attended "Anger Management" and "LifeSkills" per his court order and evaluation

28

THE GRAVITY OF OFFENDER EVALUATION AND TREATMENT WORK —CASE STUDY #2

Milchak Murders Tate Jensen, age 31



2011--One year later . . .

- Ex-girlfriend reports threats and stalking after ending relationship with Milchak
- Milchak fired two shots through the living room window, striking Jensen and killing him instantly.
- Milchak then broke the rest of the glass out of the window and entered the living room attempting to murder his ex girlfriend
- Deputies later found the holster for Milchak's .44-caliber Magnum pistol in the back seat of the woman's car,
- Milchak was inside his ex-girlfriend's car while she and Jensen were watching TV.

29

QUALITY DV OFFENDER EVALUATION AND INTERVENTION IS ESSENTIAL FOR SAFETY.

- Evaluation vs. Assessment
- Intervention vs. Treatment
- Lessons learned (Maryland, Colorado, Washington)
- What works in DV offender services and accountability?
- How do we ensure safety and best practices?
- How do we support our providers?

30

WHAT ARE OUR STANDARDS OF CARE FOR PEOPLE IMPACTED BY DV?

- Currently there are 47 states with statutory standards for DV Offender Intervention services . . . Utah is not one.
- 11 states currently use FVPSA federal funding to subsidize DV offender services . . . Utah is not one.
- The average length of mandatory DV offender intervention services in the US is currently 26 week . . . Utah requires 16.

31

UTAH DHS DOMESTIC VIOLENCE PROGRAM GUIDING PRINCIPLES AND STANDARDS OF CARE

- A person who has been victimized by domestic violence is not responsible for the abuse.
- Domestic violence is criminal behavior.
- Policies and procedures of domestic violence programs should not do harm.
- Programs for people impacted by domestic violence must provide options and referrals and respect the right to self-determination.
- Confidentiality is paramount; domestic violence programs have a responsibility to uphold the highest standards of confidentiality.
- Victim and community safety are the highest priorities and should guide the system responses of the criminal justice system, victim advocacy, human services and domestic violence offender treatment.
- The management and containment of persons convicted of perpetrating domestic violence requires a coordinated community response that includes victim advocates, human services, justice services, treatment providers and corrections.
- Successful program outcomes and safety are enhanced by increased public awareness of domestic violence.
- Domestic violence and trauma are preventable, cyclical public health issues that increase the risk of chronic illness and premature mortality
- Domestic violence is a significant adverse experience for children, jeopardizing the overall health and well being of a child over their lifetime.
- Priorities are driven by reputable, empirical data and epidemiological, defensible trends.
- There is no singular profile of a person who commits acts of domestic violence.
- Minority communities, especially tribal and LGBT communities, deserve equal representation, cultural considerations, and the acknowledgement of historical trauma in the context of domestic violence programming and policy development
- Statewide needs assessments and ongoing program evaluation must be coordinated, research-based, and conducted with regularity to support proper prioritization
- We believe domestic violence is preventable, change is possible, and collaboration is essential.

32

ADVANCING OUR SYSTEM OF CARE

- Upcoming licensing regulations/statue updates
- Coordinated response from multiple stakeholders
- Promising research and funding support
- Commitment to evidence-based practices
- Strong, re-organized victim advocacy presence
- Improved federal laws (funding, access to firearms, victim confidentiality, and equality)

33

YOU ARE ESSENTIAL.

- Quality care and research-based practices are essential to improve safety and reduce DV risk in Utah.
- Current gaps in offender evaluation and intervention services in SE Utah
- With your help, we can drive down rates of lethality and improve outcomes.

34

WE BELIEVE DOMESTIC VIOLENCE IS PREVENTABLE, CHANGE IS POSSIBLE, AND COLLABORATION IS ESSENTIAL

Thank you for your commitment to this important service.

35

Module II

Victim advocacy, safety and resources

Presented by: Liz Watson, Executive Director of the UDVC

This Module will support your ability to:

- Speak to the scale of DV in the US
- Identify common myths about domestic violence
- Recognize what DV looks like and appreciate the myriad types of abuse that constitute DV
- Reflect upon some common definitions of dv
- Review the Power & Control and Equality wheels and use them when working with clients
- Appreciate some of the less recognized abusive behaviors - animal abuse, sexual abuse, stalking
- Start to appreciate why a victim may remain in an abusive relationship

36

What is Domestic Violence ? Understanding the Dynamics of DV

This project was supported by Grant No. 2012-DW-AX-2012 and Grant No.2011-WR-AX-0008 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

Who are the victims?

- More than one in three women report having been a victim of some form of domestic violence at some point (37%). –Dan Jones Survey 2005
- Seven in ten respondents answer that a child was present in the home when domestic violence occurred (70%). –Dan Jones Survey 2005
- Each year, women experience about 4.8 million intimate partner related physical assaults and rapes. Men are the victims of about 2.9 million intimate partner related physical assaults. - Tjaden P, Thoennes N. Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey. Washington (DC): Department of Justice (US); 2000. Publication No. NCJ 181867.

What is domestic violence?

- Not so long ago there was no terminology to describe the behaviour and suffering we now readily identify under the heading of "domestic violence" . It was simply accepted that this behaviour happened in the home.
- These days almost everyone reacts to the term however and has an understanding of what it means
- But what exactly do we all understand when we hear/use the term?
- The term is quite misleading in its own right.
- In addition to which there are so many myths surrounding dv that it is easier to start with looking at what it isn't than what it is

Myths

Victims like to be beaten

Victims of domestic violence have long been characterized as women who enjoy being beaten. Evidence does not support this outdated psychological theory. Rather, victims of domestic violence desperately want the abuse to end, and engage in various survival strategies, including calling the police or seeking help from family members, to protect themselves and their children. Silence may also be a survival strategy. (Dutton, Dynamics of Domestic Violence, 1994)

Batterers abuse their partners because of alcohol or drugs

Alcohol or substance abuse does not cause perpetrators of domestic violence to abuse their partners, though it is frequently used as an excuse. Substance abuse may increase the frequency or severity of violent episodes in some cases.

(Jillson & Scott, 1996)

Because substance abuse does not cause domestic violence, requiring batterers to attend only substance abuse treatment programs will not effectively end the violence. Such programs may be useful in conjunction with other programs.

Domestic Violence is about Anger

Many assume that anger plays a large role in domestic violence; that a perpetrator gets so angry they lose control and become violent. Anger is a natural human emotion which many people experience every day without perpetrating any violence. Ultimately everyone has a choice how to deal with their anger and whether to resort to violence.

Starting to define DV

What does it mean to you?

Domestic?

- Does this mean at home?
- What relationships are covered?
- Should we even ask? Is a man's home not his castle?

Domestic?

Violence?

- Physical?
- Does this mean they have to leave a mark?
- How else do you prove "violence"?

Violence?

Starting to define DV
A Broader Perspective

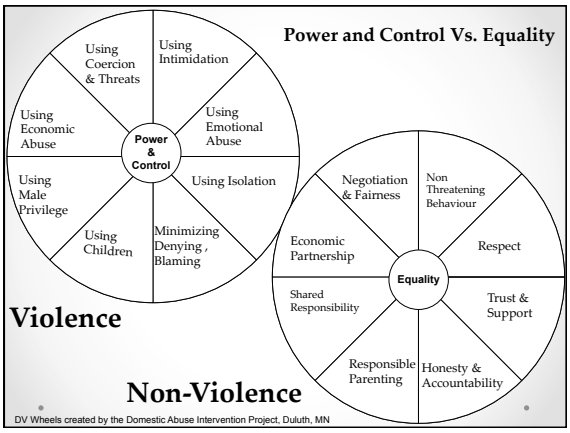
- Domestic Violence is not a simple or straightforward concept
- What we see may be the tip of the iceberg
- Sometimes what we see is very different to what a victim sees
- Physical and sexual assaults, or threats to commit them, are the most apparent forms of domestic violence and are usually the actions that allow others to become aware of the problem.
- However, regular use of other abusive behaviours by the perpetrator, when reinforced by one or more acts of physical violence, make up a larger system of abuse.

Types of abuse

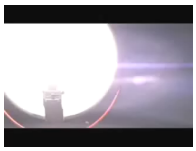
• **Physical Abuse** – When a person hurts or tries to hurt a partner by using physical force	Hitting, kicking, strangling, burning with cigarettes etc
• **Emotional Abuse -** Acts, omitted or committed with the intent to cause a partner distress, embarrassment, or fear	Stalking, name-calling, isolation, intimidation, threats, etc.
• **Sexual Abuse –** Forcing a partner to take part in anything sexual when they do not consent	Withholding contraception, forcing partner to watch pornography, rape etc.
• **Financial Abuse –** Using money or lack of to control a partner	Refusing to let a partner work, withholding access to bank accounts, running up debt to affect victim's credit score
• **Spiritual Abuse –** Using scripture, doctrine, or dogma to justify abuse;	One partner determining how or when the family worships without the family's input

Types of abuse…

"When it comes to damage, there is no real difference between physical, sexual and emotional abuse. All
that distinguishes one from another is the abuser's choice of weapons."



What do you see happening?



Animal Abuse

- Do you think there is a connection between animal abuse and domestic abuse?

Animal Abuse & DV

According to the American Humane Society,

- ….%of battered women reported violence towards their animals. …..% of these incidents occurred in the presence of the women, and ….% in the presence of the children, to psychologically control and coerce them.
- Between …..% and …..% of battered women are unable to escape abusive situations because they worry about what will happen to their pets or livestock should they leave.

Animal Abuse & DV

What's the implicit message to the victim?

- Animal abuse may be a warning sign of a violent home. Threatening, hurting or killing an animal is an indicator of the potential for increased violence/lethality
- It can be used as another tool to emotionally control, coerce and threaten a spouse, a partner, an elderly parent, or a child.

How can it impact a family?

Sexual Abuse

Do you think there is a connection between sexual abuse and domestic abuse?

Although our service system has historically separated domestic violence and sexual assault services, we know that sexual assault and domestic violence are deeply interconnected.

Sexual Abuse & DV

Consider the following:

- Perpetrators use sexual assault and the threat of sexual assault to keep victims under control and in deep fear.
- Contrary to the myth of stranger rape, in 75% of adult rapes the victim knows the perpetrator. As a result, those who have been sexually assaulted and who fear repeated sexual assault may need the same services—including emergency sheltering services—that are needed by domestic violence survivors.
- While it is true that both domestic violence and sexual assault carry strong and persistent stigma, the depth of shame that continues to be associated with sexual assault can considerably compound a person's ability to respond and recover.

Adapted from "Domestic Violence Training for New Staff" – Northnode InC

Sexual Abuse & DV

We have explored some common myths and misconceptions that make it extremely difficult for domestic violence survivors to seek and obtain help. The same kinds of barriers exist around sexual assault and society's myths and misconceptions about sexual assault are pervasive and deeply imbedded in our cultures.

Can you give an example?

These myths are part of the complex set of dynamics contributing to a victim's belief that reporting rape is a fruitless undertaking.

In addition, the process of prosecuting a rape case is likely to re-traumatize the victim. Without a strong and skilled advocate, going through this can be impossibly difficult

Sexual assault is one of the ways in which perpetrators abuse their partners—it is not separate from domestic violence

Adapted from "Domestic Violence Training for New Staff" – Northnode Inc

Stalking & DV

"A course of conduct directed at a specific person to cause a reasonable person to feel fear"

- Unwanted phone calls, letters, or emails, gifts
- Repeated physical following
- Observing the victim's actions for an extended period of time at their home, their workplace, or place of recreation
- Damaging or disabling personal property such as cars and homes
- Contacting family members, friends, or associates of the victim inappropriately
- Slanderous statements false reports
- Posting information or spreading rumors about the victim on the internet, in a public place, or by word of mouth
- Cyberstalking; technology risks

Stalking & DV

- Technological Risks for Victims
  - GPS satellite positioning devices
  - Spyware for PC's and cell phones
  - Cameras
  - Social Media *(Twitter, FourSquare, Geotagging, Facebook)*
  - Internet sites on stalking and stalking products
  - Call recorder cards or spoofcards

1 in 4 victims reported some form of cyber stalking such as email (83%) or instant messaging (33%).

1 in 13 victims reported stalkers using electronic devices to intrude in their lives.

Stalking Victimization in the U.S., BOJ 1/09

Stalking & DV

66% of female victims and 41% of male victims are stalked by a current or former intimate partner

81% of women who were stalked by an intimate partner reported that they had also been physically assaulted by that

- More likely to physically approach victim
- More insulting, interfering and threatening
- More likely to use weapons
- Behaviors more likely to escalate quickly
- More likely to reoffend

(The RECON Typology of Stalking, Mohandie et al(2006))

Stalking & DV

According to the NCVS (2002)

- *"Stalking is a key weapon in the armory of domestic abusers, indeed stalking and domestic violence intersect in a variety of ways. While stalking does not always involve domestic violence – Domestic violence almost invariably includes elements of stalking."*

Dating Violence

- Dating violence is controlling, abusive, and aggressive behavior in a romantic relationship. It can happen in straight or gay relationships. It can include verbal, emotional, physical, or sexual abuse, or a combination
- According to VAWnet, a project of the National Resource Center on Domestic Violence, it is likely that "physical aggression occurs in one in three adolescent dating relationships."
- 81% of parents surveyed either believed teen dating violence is not an issue or admit they don't know if it's an issue

Dating Violence

Anyone can be a victim dating violence. Both boys and girls are victims, but boys and girls abuse their partners in different ways

Girls are more likely to yell, threaten to hurt themselves, pinch, slap, scratch, or kick.

Boys injure girls more and are more likely to punch their partner and force them to participate in unwanted sexual activity.

- *Materials adapted from http://www.novaco.org/dvstats/teendatingviolencestatistics2010.pdf http://victimsofcrime.org/help-for-crime-victims/get-help-bulletins-for-crime-victims/bulletins-for-teens/dating-violence*

Dating Violence

- Violent relationships in adolescence can have serious ramifications for victims: Many will continue to be abused in their adult relationships and are at a higher risk for substance abuse, eating disorders, risky sexual behavior, and suicide. *(Jay G. Silverman PhD, et Al, "Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality." Journal of the American Medical Association, (2001).)*
- 50 % of youth reporting both dating violence and rape also reported attempting suicide, compared to 12.5% of non-abused girls and 5.4% of non-abused boys. *(D. M. Ackard, Minneapolis, MN, and D. Neumark-Sztainer, Division of Epidemiology, School of Public Health, University of Minnesota, Minneapolis, MN, "Date Violence and Date Rape Among Adolescents: Associations with Disordered Eating Behaviors and Psychological Health," Child Abuse & Neglect, 26 455-473, (2002).)*
- A study of 1,600 juvenile sexual assault offenders nationwide indicated that only around 33% of the juveniles perceived sex as a way to demonstrate love or caring for another person; 23.5% perceived sex as a way to feel power and control; 9.4% as a way to dissipate anger; 8.4% as a way to punish. *(California Coalition Against Sexual Assault (CALCASA) 2002 Report: Research on Rape and Violence,http://www.uasasonoma.org/teensite/statistics.htm#Child/Teen%20Vicitmization)*

Victim Confidentiality Standards

How do VAWA Section 3 and FVPSA confidentiality provisions protect victim information?

- VAWA Section 3 and FVPSA prohibit sharing personally identifying information about victims without informed, written, reasonably time-limited consent.
- These confidentiality grant conditions also prohibit programs from asking survivors to share personally identifying information as a condition of service.
- Additionally, no program can share personally identifying information to comply with Federal, Tribal, or State reporting, evaluation, or data collection requirements.
- These provisions allow survivors to request that their personal confidential information be shared by a victim service provider for a specific purpose through a time-limited, informed, and written release.
- The release of information (specific and time-limited) **must be for services requested by the survivor** and they must be fully informed of all possible consequences of disclosure, as well as alternative ways to obtain the service they are requesting.

61

Why do victims stay?

Activity - Mary

QUESTIONS?

. . .

So …..
What is Domestic Violence?

- In actual fact far from being about a loss of control domestic violence is all about power and control
  - Using tactics such as physical and sexual violence, threats, emotional abuse, financial control, legal status, harassment, stalking, etc.
  - Creating fear in victims to maintain control
  - Isolating victims from help and support

Advocacy Tool Box I

What does it mean to experience domestic violence?

This project was supported by Grant No. 2012 –DW-AX-0029 and Grant No. 2011-WR-AX-0008 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

Presentation Outline

- What a does it mean to experience domestic violence
- Issues that impact underserved communities
- Challenges to leaving an abusive relationship

What it means to experience domestic violence

- In some ways, the experience of domestic violence is universal.
- In some ways the experience of domestic violence is particular to the communities and cultures in which the violence strikes.
- Understanding this is a cornerstone of an empowering and a trauma-informed advocacy response.

Universal and unique activity

- Are there any training participants that are parents, please stand up.
- Are there any participants who were born and raised outside the United States, please stand up.
- Is anyone under the age of 25, please stand up. Is there anyone over the age of 50, please stand up.
- Is there anyone who enjoys cooking, please stand up.
- Is there anyone that is drawn to political activism, please stand up.
- Universal and unique aspects can exist simultaneously.

Universal Barriers

- **Fear of bring battered again**
- **Economic dependence**
- **Isolation**
- **Psychological harms**
  - Low self-esteem
  - Depression
  - PTSD (Post Traumatic Stress syndrome)
  - Suicide
- **Immediate and long term physical effects**
  - Injury
  - Medical difficulties later in life
  - Head injuries, chronic gastrointestinal problems, STD's
  - Pregnancy related problems

Factors for Survivors from Underserved Communities

Activity

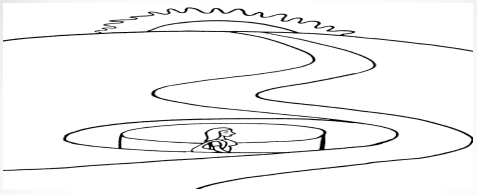
Identify the factors for specific underserved communities

Violence against people with disabilities

- **Personal care givers can abuse people with disabilities in unique ways. They might:**
  - Withhold medication, personal care, or medical equipment
  - Refuse to fix meals, feed the person, and attend to other personal care needs.
  - May not be able to hear, see or speak without assistance.
- **Dependence on the perpetrator can increase vulnerability.**
- **A person with disabilities may be economically dependent on the abuser.**
- **Accessible shelter can be difficult (or impossible) to locate.**

Domestic violence among the deaf and hard of hearing

- Deaf and hard of hearing survivors often come from a small or close-knit community.
- Perpetrator may remove the survivors ability to communicate– take cell phone, laptop, TTY, and/or hearing aids.
- Isolation in shelters and other DV programs
- Tradition of secrecy within the culture/protection of perpetrators who are members of the community (common to many minority groups)
- Lack of accessible or culturally competent services



"I am so exhausted from trying to teach the hearing system about my access rights that I cannot focus on taking care of myself. I feel like giving up"

-Deaf survivor

Domestic violence among elders

- **The longer the relationship** the harder it can be to imagine a life apart from the batterer.
- **Judges may hesitate** to order an elderly perpetrator to leave the family residence.
- **Adult children may conspire** to protect the parent batterer and/or minimize the impact of the violence.
- **Adult children may be the abusers and caretakers.**
- **Vulnerable abuse reporting law mandates** reporting of suspected abuse of an elder by a caretaker.
- **Shelter services for frail abused elders may not be adequate** to meet elders' needs for accessible services.

Domestic violence in the LGBTQ community

- **Threats to reveal the partner's orientation** to family or employers can result in job loss or the destruction of life-long relationships.
- **Historic homo/bi/trans phobia of law enforcement** can leave the GLBTQ victims of violence believing that the police will not help them secure safety.
- **Courts do not necessarily enforce laws uniformly** – though gay and lesbian people have some legal rights. Knowing this, they are hesitant to turn to the legal system.

Domestic violence in communities of color

- This country's history of violence against communities of color can leave victims of violence doubting whether that system is able or willing to respond to violence perpetrated by one person of color against another.
- Historical trauma is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma. Native Americans have, for over 500 years, endured physical, emotional, social, and spiritual genocide from European and American colonialist policy. http://historicaltrauma.com/
- Survivors of color often face a lack of culturally appropriate services as well as prevention & supportive resources in diverse languages. Adding to these challenges is a lack of collaboration with the community based social service programs that historically provide services to communities of color.

Domestic violence in immigrant/refugee communities

- **Legal protection**
  Immigrants too often assume that the law is not available to protect them from abuse.
- **Distrust of government and law enforcement**
  Some immigrants have come to the U.S. following experiences of brutality in their countries of origin. They may be deeply distrustful of government in general and of law enforcement in particular.

Domestic violence in immigrant/refugee communities

- **Fear of deportation**
  Fear can keep a non-citizen victim of violence from seeking help.
- **Language and culture**
  Domestic violence agencies/organizations may not have staff or volunteers who are able to connect with a person whose first language is other than English and whose first culture is other than North American.

Domestic violence and male victims

Societal myths:

- **Men can't be abused by women.** Men are the "stronger sex". If men disclose abuse, we make judgments about their masculinity.
- **Men who are abused aren't real men.** We are socialized to believe men are stronger emotionally and should be able to control the situation. Men may be referred to as weak, and face discrimination and ridicule if they disclose to friends, family, law enforcement.
- **Shelters and providers only help women.** Domestic violence services are available to men, although on site shelter services may be limited. Not many gender specific services for men such as support groups.

Why do they stay?

What are some of the barriers to leaving an abusive relationship?

Barriers to leaving an abusive relationship

- Love
- Threats of suicide/homicide/harm/harassment by abuser
- Pressure/lack of support from family, friends or church
- Low self-esteem, self- worth
- Not identifying what's happening as abusive
- No support system
- Self-blame or blame from others
- Pressure from children to stay/concern about c
- Don't want to divorce/break up – culturally/spi unacceptable
- The cycle of violence is familiar – the unknown the known.

Barriers to leaving an abusive relationship

- Promises of change -the hope for change is strong
- Isolation
- Societal denial
- Financial and economic dependence
- Threats of retaliation
- Leaving can be dangerous

Leaving is a process

Leaving is a process

- Leaving is a process that takes time and often multiple attempts. On average a victim will leave a violent relationship 7 times before leaving for good.
- It must be done in a way that does not further jeopardize the victim's safety as research shows that attempts to leave increase risk for victims.
  - *Of the total domestic violence homicides, about 75% of the victims were killed* as they attempted to leave the relationship or after the relationship had ended.
- It should be driven by the person experiencing the abuse no matter how much friends, family or advocates want to help.

Adapted from "Domestic Violence Training for New Staff" – Northnode Inc

Why doesn't the victim just leave?

- This question is victim blaming – places the burden upon the survivor to stop the abuse.
- Instead, let's ask:
  - Why does this person abuse?
  - What can we do to stop this behavior?

The Effects of Domestic Violence on Children

Presented by Kathy Franchek-Roa MD
Assistant Professor of Pediatrics
University of Utah School of Medicine

This project was supported by Grant No. 2012 –DW-AX-0029 and Grant No. 2011-WR-AX-0008 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/ program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

Objectives

- Understand the scope of "child witnessing" and "in the presence"
- Trauma responses and observable behaviors of children
- Healthy developmental stages and possible interruptions from DV
- Impact of repeated trauma on the developing brain
- Family and children advocacy

Current rates and trends of in Utah:

- 1 in 3 Utah women will experience IPV in her lifetime; nearly 1 in 5 will experience IPV ***THIS YEAR***. CDC
- Since 2000, DV-related homicides accounted for at least 42% of all adult homicides in Utah VIPP
- Each month, at least 1 woman is murdered by her intimate partner in the Utah; 3 DV-related suicides per month. VIPP

How does DV impact a child survivor?

- Approximately 80 of Utah's children witness their mother murdered, almost killed, or are first to find her every year in Utah.
- Less than 60% of those children received any counseling & many only one time

National Death Reporting System 2003-09 study (Logan et al '08; Smith, Fowler, Niolon '14).

Child Witnessing

Witnessing and exposure can be both direct and indirect.

- Infants and very young children may be physically caught in the crossfire of the abuse.
- Children may not be in the same room, but hear the violence.
- Children may see the evidence of the abuse in the form of bruises, black eyes injuries.

Impact on a Survivors' Ability to Parent

- The abusive partner may undermine the parental role of the survivor.
- Injuries and emotional trauma may make it difficult for the survivor to care for children.
- Children may jump to "caretaker" roles with the parent or the other siblings.

Impact of DV on Children

- Children in homes where domestic violence occurs are physically abused or neglected at a rate 15 times the national average.
- Children who are exposed to battering of their parents suffer the same harm and display the same symptoms as children who are actually abused.
- Without intervention, trauma of this degree may thread its way into adulthood.

Adverse Childhood Experiences

- ACE study documents the conversion of traumatic emotional experiences in childhood into organic disease later in life

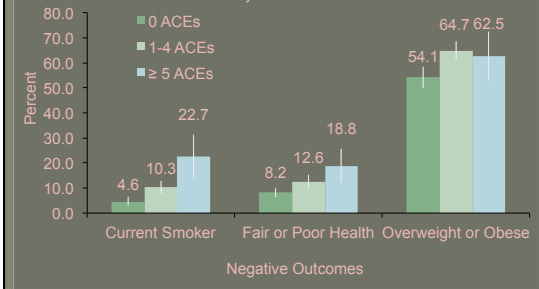
Felitti 2001

Percent Of Children with Adverse Childhood Experiences

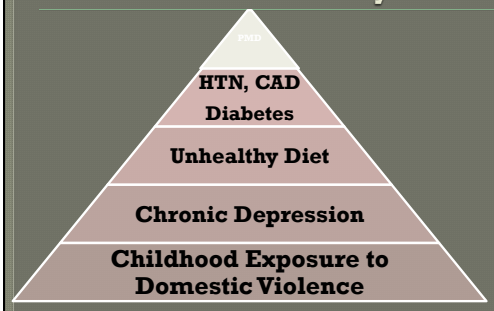
ACE	Felitti 1998 (%)	Utah 2010 (%)
Psychological Abuse	11	38
Physical Abuse	11	17
Sexual Abuse	22	20
Substance Abuse	26	28
Mental Illness	19	21
Mother Treated Violently	13	12
Criminal Behavior	3	6

Felitti 1998; No More Secrets 2012; http://health.utah.gov/opha/publications/

Percentage of adverse childhood experiences by negative outcomes, Utah, 2010



ACE Pyramid



Felitti 2001

What you may observe
Infants, Toddlers, Preschoolers

- Sleep disturbances
- Disturbances in feedings
- Feelings of helplessness and passivity
- Generalized fearlessness
- Specific new fears
- Loss of recently acquired developmental skills
- Clinginess and separation anxiety
- Thinking and talking about the traumatic event
- Irritability
- Aggressiveness
- Scanning for danger/ expecting danger
- Easily startled

What you may observe
School-Age Children

- Posttraumatic play
- Thinking and talking about the trauma outside of play
- Specific fears, triggered by traumatic reminders
- Feeling guilty about the trauma
- Fantasies of revenge
- Withdrawn behavior
- Impaired concentration; difficulty learning
- Sleep disturbances
- Headaches, stomach aches, or other physical symptoms
- Concerns about their safety, safety of others
- Aggressive behavior
- Anxiety

What you may observe
Teens

- Detachment, shame, and guilt
- Self-consciousness about their fears and intense feelings
- Abrupt shifts in relationships
- Desires for and plans to take revenge
- Radical changes in attitude and self-identity
- Premature entrance into adulthood or reluctance to leave home
- Being upset about reminders of the trauma and avoiding it
- Coping behaviors that may include self-endangering behaviors such as substance abuse/ cutting

More ACEs = More Risk for :

- **-chronic health conditions**
- **-teen pregnancy**
- **-smoking**
- **-alcohol abuse**
- **-illicit drug abuse**
- **-sexual behavior**
- **-mental illness**
- **-risk of re-victimization**
- **-instability of relationships**
- **-weak performance in the workforce**
- ***-homelessness***

The Developing Brain

"In utero and during the first four years of life, a child's rapidly developing brain organizes to reflect the child's environment."

-Maltreatment and the Developing Child Bruce D. Perry, M.s., Ph.D.

Excessive Stress/ACEs Disrupt the Architecture of the Developing Brain

- The neural circuitry for dealing with stress is especially malleable during fetal and early childhood periods
- Excessive early stress programs a child's stress hormone system to have a more exaggerated and prolonged response to subsequent stressors
- Our response must be trauma informed

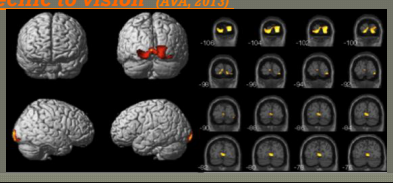
ASK: "What has happened to this person?"

Violence Impacts the Developing Child

- Physically
- Language and cognition
- Social and emotional functioning
- Sexual behavior
- Brain and physiological development

Witnessing DV as Sole Stressor. . .

Results in reduced thickness of cortex in several areas and changes in the visual-limbic pathway of left occipital lobe which is involved in *emotions, learning, and memory functions specific to vision* (AVA, 2013).



How does DV exposure/ ACE manifest in childhood?

- IQ and reading ability (Delaney-Black et al, 2003)
- Lower grade point average (Hurt et al, 2001)
- Days absent from school (Hurt et al, 2001)
- Decreased rates of high school graduation (Grogger, 1997)
- Significant deficits in attention, abstract reasoning, long term memory for verbal information, and decreased reading ability (Beers & Debellis, 2002)

Do adverse experiences alter us negatively forever?

Are the negative effects of stress inheritable?

Enter Epigenetics!

Epigenetics Remind us to Promote Mental Health in Order to Prevent Chronic Illness . . . For Ourselves and Future Generations

- "When placed in situations of unremitting stress, a person who is born with a genetic propensity to bipolar disorder, depression, or schizophrenia may in fact develop the disease. The same is true for those who are susceptible to asthma, heart disease, or cancer."

Carter, Rosalynn (2010), Within Our Reach – Ending the Mental Health Crisis. Rodale.

THE KEY TO BREAK THE CYCLE OF VIOLENCE

- Preventing Risk and Promoting Protective Factors ***Throughout the Lifespan:***
- Plasticity occurs throughout our lifespan, with large areas of brain development in childhood and adolescence
- Stabilizing the lives of adults improves the environment in which children grow and learn

What do children need?

- Support in living violence-free lives
- Educating their mothers/fathers on the impact of the violence
- Consistency in our response and interventions
- Safety planning
- Consistent positive adult role models
- A chance to be kids, doing kid-like things!

Three EARLY INTERVENTION Programs you have to know about:

- **Family Resource Facilitation**– Family Resource Facilitators (FRF) act as advocate/advisors and resource coordinators for children and families, provide information and support, and engage the child and family in a planning process that results in a unique set of community services and natural supports individualized for that child and family.
- **School-Based Behavioral Health** – Coordinated practices provide access to behavioral health services in schools, to support academic success and help keep children and families united.
- **Mobile Crisis Teams** – Partner with emergency services (911, Crisis Line, DCFS, DJJS, etc.) & provide emergency behavioral health services in the home, the school and/or the community.

"How do we know these programs work?"

During In State Fiscal Year 2013,
1867 children and youth received school-based services through the Early Intervention funding

Outcomes:

- Decreased Office Disciplinary Referrals
  Multiple schools are reporting significant reductions in ODRs. Several are reporting a reduction in the range of 50-88% when compared to last year
- Increased Academic Performance
  Multiple schools are reporting increased performance in academic testing and/or Grade Point Average.
- Decrease in Suspensions, Truancy, Absenteeism & Tardies
  Outcomes include a 50% decrease in days suspended, a 30% decrease in truancy, a 36-97% reduction in absenteeism & a 46-77% reduction in tardies

Safety planning with children

- Short and specific
- Identify safe people and safe places
- Role play calling 911
- "Hands are for helping" – identify a safe person or a safe place for every one of their fingers; trace a hand on a paper and write them down
- Encourage mom's participation in the safety plan consciously giving the children permission to act and get help

Mandatory Reporting Laws

- Child Abuse/Neglect Reporting (62A- 3-305 UCA)
  - Anyone who has reason to believe… must report to DCFS or Law Enforcement; class B misdemeanor for willful failure to report
- Vulnerable Adult Abuse, Neglect and Exploitation (62A-3-305& 76-5-111.1 UCA)
  - Anyone who has reason to believe… must report to APS or Law Enforcement; class B misdemeanor for willful failure to report
- Healthcare Provider Reporting (26- 23a-2 UCA)
  - Applies to any healthcare provider treating injuries the provider has reason to believe were caused by dangerous weapon or by criminal means; class B misdemeanor for willful failure to report

Domestic Violence Related Child Abuse

- Children witness violent physical or verbal interactions between adults living in the household and *at least* one of the following occurred:
  - The alleged perpetrator used or threatened to use a dangerous weapon
  - The alleged perpetrator threatened to cause substantial or serious bodily injury
  - The alleged victim sustained substantial or serious bodily injury
  - There is a pattern of two or more CPS investigations of DV-related child abuse within the previous 2 years
  - Another allegation of abuse, neglect, or dependency is being accepted or is in the process of being investigated
- Mandatory Reporting Policy
  "Anyone", "Reason to believe", "Class B Misdemeanor" (failure to report **Utah Code 62A-4a-403**

Child Abuse: Domestic Violence in the Presence of a Child

- Remember to recognize children as witnesses
- Remember to recognize children as victims
- Remember to notify DCFS (child abuse reporting section 62A-4a-403 duty of police)
- Remember possible additional criminal offense

How can people report child welfare concerns:

- Anonymously
- By giving name and contact information
  (law prohibits DCFS from telling the family who contacted us with the allegations)
- Phone is the best way to report

24 hour reporting hotline:

1-855-323-3237

HOPE

- Children who have been exposed to violence, as victims or witnesses, need skilled intervention to overcome the effects of their experiences. But they *can* overcome this legacy, and feel loved, secure, and hopeful.

Resources

- Trauma Informed Advocacy Tipsheets, National Center for Trauma, Mental Health, and Domestic Violence, 2012.
- Homeostasis, Stress, Trauma, and Adaptation: A Neurodevelopmental View of Childhood Trauma; Bruce D. Perry, MD, Ph.D, and Ronnie Pollard, MD
- Promising Futures, Futures without Violence, www.PromisingFuturesWithoutViolence.org
- Six Core Strengths for Healthy Child Development, The Child Trauma Academy, Bruce D. Perry, MD, Ph.D, 2002

UDVC Live Basic DV Training

The Utah Law Enforcement Response to Domestic Violence

Presented by Detective Justin Boardman
Special Victims, WestValley City Police Dept.

This project was supported by Grant No. 2011-WR-AX-0008 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

UDVC Live Basic DV Training

Domestic Violence Happens…

- Every day in Utah law enforcement is dispatched to calls of violence.
- Every community is a victim of domestic violence.
- Law enforcement has been given the mandate to respond **first**.
- How law enforcement responds is now mandated by law.

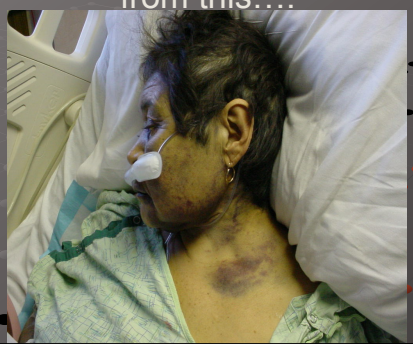
UDVC Live Basic DV Training

Individual Officer Response

- Despite the legal responsibility to respond and follow the law, individual officers have personal response styles and attitudes.
- These response styles and attitudes are greatly determined by the officers' experience and training.

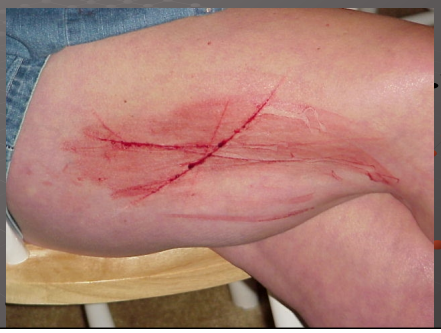
UDVC Live Basic DV Training

Officers experiences may vary from this….



UDVC Live Basic DV Training

…to this.



UDVC Live Basic DV Training

Historical Perspective in Utah

- Prior to 1994-1995, laws were completely different.
- Law enforcement used to respond to "Family Fights". They were trained in the Police Academy to respond, separate, calm things down, act as peace keepers, and there was no consistent response or plan.

UDVC Live Basic DV Training

Historical Perspective

- "Family Fights" as they were referred to, were considered "family issues" and many felt that no one else should interfere.
- Depending on the area in Utah, there were very few resources for battered or abused women.
- The law used to require victims to make all the major decisions when officers responded.
  - Misdemeanor offenses committed outside of officers presence required victims to make "Citizens Arrests".
  - Victims had to sign complaint which officers would sign and witness.

UDVC Live Basic DV Training

Victim dynamics were the same

- After police would leave, victims would realize how difficult the situation was, most would stay with abuser, and victims would call police or prosecutor and want charges dropped.

UDVC Live Basic DV Training

Problems with that response

- Multiple responses
- Very often officers would not even write a report unless there was an arrest.
- No prosecution if victim refused to testify
- Officer frustration, prosecutor frustration, victim frustration
- Children grew up and continued abuse cycle

UDVC Live Basic DV Training

What has changed for Law Enforcement Officers?

- Family Fights became Domestic Violence.
- **Understanding of the Dynamics of** Domestic **Violence happened, and the law changed.**
- **The Cohabitant Abuse Statute was born!**
- **Law enforcement now had specific responsibilities that required action.**
- **Discretion was taken away from officers, no matter where they worked.**

UDVC Live Basic DV Training

The New Law

- The law made officers focus on identifying who was abusing and who the victims were. Primary/Predominant Aggressor became a key word and focus.
- The law required mandatory arrests if evidence was present that laws were violated.

UDVC Live Basic DV Training

The New Law!
The Cohabitant Abuse Statute

- 16 years of age or older, or emancipated,
- AND
- Is, or was a spouse of the other party
- Is, or was living as if a spouse of the other party
- Is related by blood or marriage
- Has or had one or more children in common
- Biological parent of unborn child
- Resides, or has resided, in the same residence

UDVC Live Basic DV Training

PRIMARY RESPONSIBILITIES of Law Enforcement

- Protect the Victim
- Enforce the Law
- Determine Predominant Aggressor
- Write a report of the incident , document it!
- Mandatory arrest without a warrant (an Officer Shall) if P.C. exists that act of Domestic Violence occurred
- Citation, or Physical Arrest and booking in Jail

UDVC Live Basic DV Training

PROBABLE CAUSE

- **What is Probable Cause?**
- **Compare to reasonable suspicion, preponderance of evidence.**
- **The law says an officer may consider the following:**
- **Excited Utterances**
  - **(Exception to Hearsay Rule)**
- **Physical Evidence. Injuries, damage to property, things officers can see or hear.**
- **Independent witnesses.**

UDVC Live Basic DV Training

Probable Cause (continued)

- Prior documented history of domestic violence
- Weapons used
- 9-1-1 tape
- Medical Reports
- Seriousness of the injuries/threats of violence
- Probable Cause is evidence that a crime was committed

UDVC Live Basic DV Training

DETERMINING PREDOMINANT AGGRESSOR (77-36-2.2(3))

- **What is predominant? What is primary?**
- **Are there differences?**
- **By statute, officers must determine Predominant Aggressor**
- **This is one of the hardest things for officers to determine**
- **Problems that make it difficult to decide**
  - **Who is telling the truth, conflicting stories, both have injuries, attitudes, alcohol or drugs, uncooperative victims/suspects**

UDVC Live Basic DV Training

Predominant Aggressor (continued)

- Prior history, complaints of abuse
- Relative severity of injuries to one or both parties
- Did one of the parties act in self-defense?
- Officers are to arrest the Predominant Aggressor

UDVC Live Basic DV Training

Self Defense

* Officers are required to determine if self defense was used by either party.
- Question? Are there laws defining self defense?
- YES
- 76-2-402 (1) Utah Code

UDVC Live Basic DV Training

Self Defense

- A person is justified in threatening or using force against another when and to the extent that he or she reasonably believes that force is necessary to defend himself or a third person against such other's imminent use of unlawful force.

UDVC Live Basic DV Training

Elements of Self Defense

- The person using force had a reasonable belief that he/she was at risk of bodily harm.
- The risk of harm was actual or imminent.
- The force used to defend was reasonable and necessary to prevent or stop the infliction of bodily harm.

UDVC Live Basic DV Training

Difficulties in Establishing Self Defense

- How much force can be used? What is reasonable?
- When does force being used as a defense become non-defensive?
- What if both parties have injuries?

UDVC Live Basic DV Training

Issues Relating to Mandatory Arrest

- ****** Citation or Book in Jail ******
- **What determines when abuser/aggressor goes to jail?**
- **Serious bodily injury.**
- **Use of a dangerous weapon.**
- **Violation of a Protective Order.**
- **Probable Cause to believe VIOLENCE WILL CONTINUE.**
- **Remember the purpose of D.V. Laws. "Identify and Protect Victims"**

UDVC Live Basic DV Training

Serious Bodily Injury

- 76-1-601
- "Serious Bodily injury" means bodily injury that creates or causes serious permanent disfigurement, protracted loss or impairment of the function of any bodily member or organ, or crates a substantial risk of death."

UDVC Live Basic DV Training

DANGEROUS WEAPON

- **76-1-601**
- **"Dangerous Weapon means any item capable of causing death or serious bodily injury; or, a facsimile or representation of the item; and, the actor's use or apparent intended use of the item leads the victim to reasonable believe the item is likely to cause death or serious bodily injury; or the actor represents to the victim verbally or in any other manner that he is in control of such an item."**

UDVC Live Basic DV Training

VICTIM ADVOCACY

- **Duties of Law Enforcement Officers 77-36-2.1**
- **"A law enforcement officer who responds to an allegation of domestic violence shall use all reasonable means to protect the victim and prevent further violence, including:**
- **Take action reasonably necessary to provide for the safety of the victim and any family/ household member**
- **Confiscate weapons**
- **Make arrangements for shelter**
- **Provide protection to victim to remove essential personal effects**

UDVC Live Basic DV Training

Duties of officers (continued)

- **Arrange, facilitate, or provide for the victim and any child to obtain medical treatment**
- **Arrange, facilitate or provide the victim with immediate and adequate notice of the rights of victims and of the remedies and services available to victims of domestic violence.**
- **Provide written notice of rights and remedies available**
- **Information on Protective Orders**
- **List of shelters, services and resources available**

UDVC Live Basic DV Training

Service of Protective Orders

- 30-6-4.2(8)(b)(i)(ii)
- County Sheriff
- Local Law Enforcement Officer
  - Any certified Law Enforcement officer may serve a valid PO.
- Service is free
- Once served, PO's are placed on the Statewide network

UDVC Live Basic DV Training

Firearms

- It is a federal crime to possess a firearm while subject to a valid protection order (18 USC 922(g)(8))
  - Limited police and military exemption; may only carry duty weapon while on duty.
- It is a federal crime to possess a firearm after conviction of a qualifying state misdemeanor of domestic violence; includes child abuse. (18 USC §922(g)(9))
  - No police or military exemption

UDVC Live Basic DV Training

Interstate Domestic Violence

- Crossing state line w/ intent to physically injure spouse or intimate partner (18 USC 2261(a))

-OR-

- Forcing or coercing intimate partner to cross state line and force or coercion leads to physical harm to intimate partner (18 USC 2261 (a)(2))

UDVC Live Basic DV Training

Interstate Violation of a Protective Order

- Crossing state line w/ intent to violate protective order which protects the victim against violent threats, repeated harassment or bodily injury (18 USC 2262(a)(1))

UDVC Live Basic DV Training

The Law Enforcement Response

- Is just the first step in the process or system.
- Police sometimes get it wrong. What are the consequences?
- The response may initially save lives. The rest of the system's responses may also save lives.
- Wherever you are in the system, realize your potential impact. Be committed, don't give up, never surrender to cynicism.

Community-Based and Systems Advocates

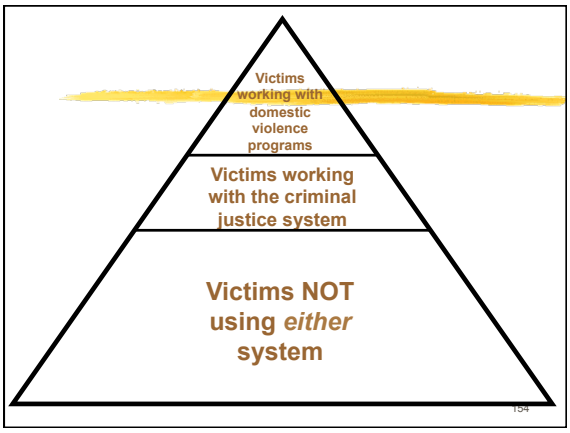
Presented by Kortney Hughes
Victim Services Coordinator
Provo Police Department Special Operations

152

Advocacy is a Process

- **Enhances** the safety of victims of sexual and domestic violence
- **Ensures** the responsiveness of all community systems to their needs
- **Holds** abusers accountable
- **Ends** violence against women

153



Evolution of Advocates

- Community-Based Advocates – working in independent, community–based agencies where victims of domestic violence seek services
- Systems Advocates, commonly known as Victim Witness Advocates or Coordinators, working in law enforcement and prosecutor offices where victims are witnesses in criminal cases

155

CB Advocate VW Advocate

- Victim/family support and advocacy
- Information
- Holistic service
- Critical thinking
- Risk assessment and safety planning
- Promote authority/ resources
- Restoration
- Community organizing

- Victim assistance
- Information
- Police/DA assistance
- Investigation
- Case-based service
- Notice on case developments
- Risk assessment and threat management
- Victim enlistment
- Compensation

156

CB Advocate VW Advocate

- Cooperate with the criminal/civil justice systems, but not always
- Work to meet the multiple needs of victims
- Help victims identify their options
- Don't tell victims what to do – let them make own choices
- Encourage victims to participate in the criminal justice system
- Help develop a more "user friendly" system
- Help victims recover in the aftermath of crime
- Facilitate the process of prosecuting cases, getting POs or serving as a liaison with law enforcement

157

Contact with victim

- Therapists are expected to integrate the victim's response into their work
  - Why is this?
  - What is the best way to obtain this information?

158

Additional Resources

- UDVC LINKLine 1-800-897-5465
- 14 Non Profit Domestic Violence Victim Service Providers in Utah
- 2 State-run Shelters in Utah
- UCASA - Sexual Violence Coalition in Utah www.ucasa.org
- Rape Recovery Center 24-hour crisis line at 801-467-7273 www.raperecoverycenter.com

159

Module III
Domestic Violence Offender Evaluations

Martha Burkett Fallis, LCSW
Derrik Tollefson, PhD, LCSW

Module III

This Module will support your ability to:
Conduct DV Offender Evaluations
Apply the Risk and Needs Principles
Choose the best assessment instruments

161

What is a Domestic Violence Offender Evaluation?

- Provided by a mental health professional (per Utah statute **77-36-5** (5) and 62A-2-101)
- Court ordered for adjudicated felony and misdemeanor DV charges
- Comprehensive behavioral health assessment PLUS key offender risk and need information
- Standardized format useful to courts, probation and parole, offender, victim and treatment provider

162

Elements of a DV Offender Evaluation

- Prior DV offenses and/or protective orders
- Substance abuse/dependence
- Mental health diagnosis, medication, and treatment
- Suicidal and homicidal thoughts/behaviors
- Use of weapons, access to firearms
- Criminal activity (non-DV)
- Obsession with the victim/ stalking
- Physical health, family and relationships
- Lethality assessment
- Police report, court order and any associated medical reports
- Safety concerns, including victim feedback
- Family violence and child abuse
- Attitudes that support/condone spousal abuse
- Prior DV services, and participation/completion information
- Current contact/separation from victim
- Employment and housing
- Involvement with peers who have pro-criminal influence
- Motivation for and amenability to treatment

163

Why is an Offender Evaluation Necessary?

- Purpose: Offender evaluation determines level of risk and need, promotes coordinated response and improves safety and accountability
- Goal: Connects the offender to the appropriate level of intervention and accountability
- Not a traditional "mental health assessment"

164

Goals of Assessment

- Sonkin & Leibert (2003) have identified 10 assessment goals:
  - ***Providing informed consent and disclosure of program expectations***
  - ***Procuring Appropriate Authorizations to Release Information***
  - ***Developing Rapport with the Client***
  - ***Assessing the Patient's Motivation for Treatment***

Goals of Assessment

- *Determine the Clinical Diagnosis of Patient*
- *Screen for Neurological Impairment*
- ***Assess the Patient's Violence and Social Histories***
- ***Assess the Patient's Risk for Further Violence***
- ***Assess the Client's Suitability for Treatment***
- *Treatment Planning and Collateral Contacts*

Providing informed consent and disclosure of program expectations

- Informed consent- communicate expectations, benefits, risks, and consequences.
- Disclosure statement- fees, duration of treatment, confidentiality, missed appointments, etc.
- Be clear about Partner Contact policies. DHS rules require Partner Contact. Be sure to inform partners concerning the limits of treatment and caution against "fantastic" expectations.

Elements of a DV Offender Evaluation: Obtaining the Criminal History

- Police report of incident
- Criminal background check (BCI)
- Sample BCI and how to read these materials
- Pre-sentence Investigation (PSI)

168

Procuring Appropriate Authorizations to Release Information

- A good assessment will require gathering information from multiple sources including current and past partners, social service and mental health practitioners, law enforcement, spiritual advisors, etc. Be clear about what information will be requested and/or shared. Complete confidentiality can't be guaranteed.
- Criminal Background Check Authorization is also needed.

Developing Rapport with the Client

"Much of what is defined as necessary for effective treatment by probation departments, state legislatures, and battered women advocates is defined by confrontation, limit-setting, consequences, and self-responsibility. A steady diet of these interventions may be sufficient for some patients with a more healthy psychological personality; however, many of the patients referred by the courts do not fall into this category." ..... "It is critical that persons working with perpetrators approach their patients with compassion and understanding, and with a belief in the process and a conviction in the importance of the goals. Therapists need to examine their own negative attitudes toward people who use violence, or else these feelings and beliefs will be communicated to their patients, either overtly or unconsciously." - Sonkin & Leibert, 2003

Developing Rapport

- Confrontational approaches have not been supported by clinical outcome studies. Therapist behaviors associated with this approach have been shown to predict treatment failure…
- Accurate empathy, an almost exact opposite of confrontation is associated with successful outcomes
  - Accurate Empathy involves skillful reflective listening that clarifies and amplifies the client's own experience, without imposing the therapist's own material. (Miller & Rollnick, 1991)

Assessing the Patient's Motivation for Treatment

- "Treatment programs sow the seeds of their own failure when, by design, they do not accommodate clients' readiness for change or motivational level…. the research shows that failure to accommodate the client's state of readiness can spell the failure of the most expensive, thoughtful, extensive treatment programs" (Miller, Duncan and Hubble, 1997, pp. 102-104).
- Assessment should include efforts to determine the degree to which the client is ready for or engaged in change. Assessment can also include efforts to motivate the client to change or continue change efforts.

Assessing the Patient's Motivation for Treatment

- The Transtheoretical Model of Change (Prochaska & DeClimente, 1992) offers one way for therapists to think about the design and implementation of treatment that has been found to increase the client's participation in therapeutic relationship. Clinicians can also use the model to assess where a client is in the change process.
- The 4 stages of the model are:
  - **Precontemplation-** Has no intention to take action within the next 6 months
  - **Contemplation-** Intends to take action within the next 6 months.
  - **Action-** Has taken steps towards changing overt behavior within the past 6 months.
  - **Maintenance-** Has changed overt behavior for more than 6 months.

Assessing the Clients Readiness for Change

- Stages of Change Measures- URICA
  - The URICA (The University of Rhode Island Change Assessment) was developed to assess the client's readiness to work on the "problem" that brought them to treatment.
  - The URICA has been shown to be reliable and valid.
  - The URICA is easily administered and scored.

Stages of Change Measures- URICA

- Sample questions from the URICA questionnaire are:
  - Precontemplation, "As far as I'm concerned, I don't have any problems that need changing."
  - Contemplation, "I have a problem and I really think I should work at it."
  - Action, "At times my problem is difficult, but I'm working on it."
  - Maintenance, "I may need a boost right now to help me maintain the changes I've already made."

Stages of Change Measures- URICA-DV

- The URICA-Domestic Violence (URICA-DV) scale is a shorter version of the URICA that is used to assess the client's readiness to change with regards to domestic violence.
- The URICA-DV is a four dimensional stage measure that assesses batterers' readiness to end their violence. The URICA-DV is broken down into four dimensions representing Precontemplation, Contemplation, Action, and Maintenance.
- **Research with Batterers using a stages of change model suggest that these clients come to programs at different change stages and therefore require different types of interventions. A one-size-fits-all approach is not appropriate (Levesque, Gelles, & Velicer, 2000).**

Sample of URICA- DV Questions

- Precontemplation, "There's nothing I can do to end the violence in my relationship."
- Contemplation, "More and more I'm seeing how my violence hurts my partner."
- Action, "I'm making important changes and ending the violence in my life." And,
- Maintenance, "I've made some changes and ended the violence, but I'm afraid of going back to the way I was before."

URICA-DV available from http://www.prochange.com/

Stage-Based Motivational Tasks

- Precontemplation: Raise doubt- increase the client's perception of risks and problems with current behavior
- Contemplation: Tip the balance- evoke reasons to change, risks of not changing, strengthen the client's self-efficacy for change
- Action: Help the client to take steps toward change
- Maintenance: Help the client identify and use strategies to prevent relapse. (Miller & Rollnick, 1991)

Assess the Client's Violence and Social Histories

- Information related to the client's violence and social histories should be obtained from several sources including:
  - The Client (clinical interview and instruments such as the Revised Conflict Tactics Scale or the Abuse of Partner Scales)
  - The Client's current and/or former Partners (interview and instruments such as the Danger Assessment)
  - Police Reports and Criminal Records (BCI)
  - Child Protection Agencies
  - Others who might be able to provide objective information (e.g., spiritual advisors)

Social History

- Social History should focus particularly on:
  - Family of origin,
  - Education,
  - Employment history,
  - SUBSTANCE USE/ABUSE history, and
  - PSYCHIATRIC history

*Research has consistently identified a relationship between these factors and treatment failure and recidivism (Tollefson, 2000; Tollefson & Gross, 2008).

Assessing General Offending Behavior

- The National Institute of Corrections recommends assessing DV offenders using a general third generation assessment tool such as the LSI-R (LS/CMI), Compas, OAS (Offender Screening Tool – Arizona), etc. There is evidence that these tools do identify DV offenders, especially those who are also involved in other offenses, better than offense-specific assessments.

Assessing General Offending Behavior

The LSI-R shows excellent prediction of violence as well as general offending, and a recent study showed the LSI-R to have better predictive ability than the PCL-R—a known violence prediction tool.

- **Level of Service Inventory–Revised**
- **PCL–R™: 2nd Ed. Hare Psychopathy Checklist–Revised: 2nd Edition**

See http://static.nicic.gov/Library/023364.pdf for the full report on DV Risk Assessment.

Tools for Assessing Use of Violence in Intimate Relationships- CTS-2

- Revised Conflict Tactics Scale (CTS-2)
  - The Conflict Tactic Scales (Straus & Gelles, 1990) has been the most widely utilized domestic violence assessment measure by researchers and clinicians to identify the types and frequency of violence within intimate relationships. The CTS-2 consists of 78 questions that assess reasoning, psychological aggression, sexual coercion, physical assault, and injury.
  - It is quick to administer and easy to score.
  - The revised version of this scale (CTS2; Straus Hamby, Boney-McCoy, & Sugarman, 1996) lists each behavior twice, asking once what the participant/patient has done to his or her partner and once what the partner has done to the participant/patient. The CTS-2 also includes sexual abuse and physical injury scales.

Sample of CTS-2 Items

- 17. I pushed or shoved my partner 0 1 2 3 4 5 6 7
- 18. My partner pushed or shoved me 0 1 2 3 4 5 6 7
- 19. I used force (like hitting, holding down, using a weapon) to make my partner have oral or anal sex 0 1 2 3 4 5 6 7
- 20. My partner did this to me 0 1 2 3 4 5 6 7
- 21. I used a knife or a gun on my partner 0 1 2 3 4 5 6 7
- 22. My partner did this to me 0 1 2 3 4 5 6 7
- 23. I passed out from being hit on the head by my partner during a fight 0 1 2 3 4 5 6 7
- 24. My partner passed out from being hit on the head in a fight with me 0 1 2 3 4 5 6 7
- 25. I called my partner fat or ugly 0 1 2 3 4 5 6 7
- 26. My partner called me fat or ugly 0 1 2 3 4 5 6 7

Tools for Assessing Use of Violence in Intimate Relationships- PAS

- Abuse of Partner Scales (Physical & Non-Physical)
- Partner Abuse Scales (Physical & Non-Physical)
  - Comprehensive, easy-to-score scales developed by Walter Hudson that can be completed by offenders and their partners. Scales can be obtained from www.WALMYR.com
    - The CTS-2 and Hudson scales can be used as program evaluation tools

Taylor-Johnson Temperament Analysis-TJTA

The brief 180-question test can be administered to individuals, couples, or groups in about 30 minutes (non-timed); is applicable for use with adolescents through senior adults.

Measures 9 personality traits and their opposites

Measures 18 dimensions of personality (9 bipolar traits) that are important components of individual adjustment and interpersonal relationships

186

STAXI-2

- Developed to assess state anger, trait anger, and anger expression and to measure the way these components contribute to medical conditions. **Scales assess anger intensity and frequency**
- The State Anger scale assesses the intensity of anger as an emotional state at a particular time; it includes three subscales.
- The Trait Anger scale measures how often angry feelings are experienced over time; it includes two subscales.
- The Anger Expression Index is an overall measure of total anger expression.

187

Sample of Abuse of Partner Scale Items

- Non-Physical Abuse Items
  - I make fun of my partner's ability to do things
  - I expect my partner to obey
  - I don't want my partner to have any male friends
  - I scream and yell at my partner
- Physical Abuse Items
  - I push and shove my partner around violently
  - I make my partner afraid for her life
  - I violently pinch or twist my partner's skin
  - I throw dangerous objects at my partner

Tools for Assessing Use of Violence

- The CTS-2 and Partner Abuse Scales are useful for assessing type(s), frequency, and severity, and duration of use of violence but should not be used to assess risk for future use of violence;
- Empirically-based risk assessment instruments should be used for this purpose.

Sexual Violence & Abuse

- Research show that women who are beaten by their partners are often also the victims of sexual violence as well (and visa versa).
- There is a critical gap in the level of knowledge we have about sexual violence in this context.
  - **Screening for Sexual Violence: Gaps in Research and Recommendations for Change** by Lynne Stevens with contributions from Barbara Sheaffer (December 2007). VAWANET.org
- What are we to do?

Assess the Client's Risk for Further Violence

- The information gathered through the process of collecting violence and social histories can and should be used to determine level of risk for re-offense.
- Risk Assessment findings should be shared with "stakeholders" such as partners, judges, probation officers, etc. That you will do this should be made clear from the beginning (informed consent, release of information, etc.).

Risk Assessment

- "Prediction is very hard to do - especially if it is about the future" (Yogi Berra)
- (taken from J. Campbell et al. presentation, June 2001)

Risk Assessment Tools

- Risk for Lethal Violence
  - Danger Assessment Domestic Violence Screening Instrument
- Risk for Reoffense
  - Domestic Violence Screening Instrument
  - Spousal Assault Risk Assessment
  - Ontario Domestic Abuse Risk Assessment

Danger Assessment

- **The 15-question Danger Assessment (Campbell, Sharps, & Glass, 2000) is designed to measure a woman's risk for lethal violence in intimate relationships.**
- **Women who score 8 or higher at "grave risk" for lethal violence; a score of 4 or higher indicates "great risk".**
- **Highest risk factors are:**
  - **Partner used or threatened with a weapon (20 times more likely to be killed)**
  - **Partner threatened to kill woman (15 times more likely to be killed)**
  - **Partner tried to choke woman (10 times more likely to be killed)**
  - **Partner violently and constantly jealous (9 times more likely to be killed)**
  - **Woman forced to have sex when not wanted (7.6 times more likely to be killed)**
  - **Gun in the house (6 times more likely to be killed)**
  - **Drug use and frequent intoxication ranked 10th and 11th.**

http://www.dangerassessment.org/WebApplication1/
Powerpoint: http://www.son.jhmi.edu/research/Homicide/Lethality%20Assessment.pps

Risk for Reoffense Tools- DVSI

- The **Domestic Violence Screening Instrument (DVSI)** was created by Colorado Division of Probation Services. To determine the risk factors for inclusion in the DVSI, DPS staff conducted a review of current literature on domestic violence risk prediction and an analysis of data collected on more than 9,000 domestic violence cases previously sentenced to probation.
- The DVSI was designed to be a short, easy criminal history review that could be made available for review by prosecutors, judges and probation officers soon after an offender is arrested. The instrument contains 12 questions related to past criminal and social history that can be answered by victim input, review of criminal history, as reported by state and national databases, and review of prior court and probation records. The instrument is not designed to include an interview with the defendant in order to avoid Constitutional concerns about communication with the defendant prior to adjudication (but it certainly could incorporate information obtained from the offender).

DVSI

- The DVSI provides a mechanism to identify offenders who have historically been non-compliant with court and/or probation orders, have perpetrated repeated intimate partner violence and are otherwise perceived to be a high risk to a specific individual or the community. Those individuals identified by the DVSI as being higher risk are in need of more evaluation prior to sentencing.
- A score of 8 or higher on the DVSI indicates high risk for reoffense (Houghton & Williams, 2002).
- A study conducted by Houghton & Williams (2002) indicate that the DVSI is useful as a predictive and screening instrument.

DVSI Items

- **ITEM #1: PRIOR NON-DOMESTIC VIOLENCE CONVICTIONS**
- ***Definition:*** (1) Include convictions only (this includes deferred sentences), (2) Non-domestic violence-enhanced crimes only, and (3) Include municipal, misdemeanor and felony convictions.
- **ITEM #2: PRIOR ARRESTS FOR ASSAULT, HARASSMENT OR MENACING**
- ***Definition:*** (1) Any arrests for assault, harassment or menacing, (2) Does not have to be a domestic violence enhanced crime.
- **ITEM #3: PRIOR DOMESTIC VIOLENCE TREATMENT**
- ***Definition:*** (1) Any court-ordered or voluntary domestic violence treatment or counseling.
- **ITEM #4: PRIOR DRUG OR ALCOHOL TREATMENT**
- ***Definition:*** (1) Any court-ordered or voluntary drug and/or alcohol treatment or counseling.
- **ITEM #5: ANY HISTORY OF DOMESTIC VIOLENCE RESTRAINING ORDERS**
- ***Definition:*** (1) Include any civil protection orders, criminal no-contact orders or domestic relations restraining orders that are put in place as a result of domestic violence.
- **ITEM #6: ANY HISTORY OF VIOLATION(S) OF DOMESTIC VIOLENCE RELATED RESTRAINING ORDERS**
- ***Definition:*** (1) Include any violations known, regardless of whether there was an arrest.
- **ITEM #7: ANY EVIDENCE OF OBJECT USED AS A WEAPON IN COMMISSION OF A CRIME**
- ***Definition:*** (1) Object is interpreted loosely to include bats, phones, tools, etc., (2) Include any evidence from any crime that included a weapon, (3) Evidence may come from police reports or testimony.
- **ITEM #8: WERE CHILDREN PRESENT DURING THE DOMESTIC VIOLENCE INCIDENT**
- ***Definition:*** (1) Any evidence to show that children were in the vicinity of the domestic violence incident.
- **ITEM #9: CURRENT EMPLOYMENT STATUS**
- ***Definition:*** (1) Indicate whether the person is currently employed.
- **ITEM #10: HAS VICTIM SEPARATED FROM THE DEFENDANT WITHIN THE PAST 6 MONTHS**
- ***Definition:*** (1) Refers to physical separation, (2) Separation may include going into shelter, moving out, moving in with friends or evicted the defendant.
- **ITEM #11: DID VICTIM HAVE A RESTRAINING ORDER AT THE TIME OF OFFENSE**
- ***Definition:*** (1) Include regardless of whether the defendant was charged with violation of the restraining order, (2) Include any civil or criminal restraining or no contact orders.
- **ITEM #12: WAS DEFENDANT UNDER ANY FORM OF COMMUNITY SUPERVISION AT TIME OF OFFENSE**
- ***Definition:*** (1) Include probation, parole, private probation, pre-trial release, bond, etc.

Risk for Reoffense Tools- SARA

- **Spousal Assault Risk Assessment Guide (SARA),** developed by researchers at the British Columbia Institute on Family Violence, helps criminal justice professionals predict the likelihood of future domestic violence and formulate appropriate case management strategies for domestic violence offenders. The instrument is a combination of static (fixed and unchangeable) and dynamic (variable) factors that relate to a person's risk for re-offense. The instrument was validated in a study of adult male domestic violence offenders entering the criminal justice system in Canada.
- The SARA is an in-depth assessment that involves an interview with the defendant, an interview with the victim and collection of collateral material. The instrument provides numerical coding and allows raters to determine a summary risk rating. The instrument does not require the rater to be a licensed mental health professional; therefore, probation officers, after training, are qualified to assess offenders using the instrument.
- The SARA was normed on 2,309 adult male offenders—1,671 probationers and 638 inmates (Kropp et al., 2000).
- Studies conducted by Skilling (2002) and Houghton & Williams (2002) indicate that the SARA is useful as a predictive and screening instrument.

SARA Items

1. Past assault of family members. 2. Past assault of strangers or acquaintances. 3. Past violation of conditional release or community supervision. 4. Recent relationship problems. 5. Recent employment problems. 6. Victim of and/or witness to family violence as a child or adolescent. 7. Recent substance abuse/dependence. 8. Recent suicidal or homicidal ideation/intent. 9. Recent psychotic and/or manic symptoms. 10. Personality disorder with anger, impulsivity, or behavioral instability. 11. Past physical assault.12. Past sexual assault/sexual jealousy.13. Past use of weapons and/or credible threats of death.14. Recent escalation in frequency or severity of assault.15. Past violation of "no contact" orders. 16. Extreme minimization or denial of spousal assault history.17. Attitudes that support or condone spousal assault.18. Severe and/or sexual assault. 19. Use of weapons and/or credible threats of death.20. Violation of "no contact" order.

- **A score of 12 or higher on the SARA indicates high risk for reoffense (Houghton & Williams, 2002).**
- **https://www.mhs.com/ecom/(rido3qbl2gyfii3hy5udbq55)/product.aspx?RptGrpID=SAR**

Ontario Domestic Assault Risk Assessment-ODARA

- The ODARA was originally developed for front-line police officers but is available for use by victim services, health care workers, probation and correctional services personnel in addition to domestic violence caseworkers in some provinces.
- Assesses risk of future wife assault in addition to the frequency and severity of these assaults.
- Although it was not designed to predict risk of lethality, the authors have found a correlation between higher ODARA scores and more severe assaults in the future.

200

ODARA Items

- 1. Prior domestic assault (against a partner or the children) in police records
- 2. Prior nondomestic assault (against any person other than a partner or the children) in police records
- 3. Prior sentence for a term of 30 days or more
- 4. Prior failure on conditional release including bail, parole, probation, no-contact order
- 5. Threat to harm or kill anyone during index incident 6. Confinement of victim during index incident 7. Victim fears (is concerned about) future assault 8. More than one child altogether
- 9. Victim has a biological child from a previous partner
- 10. Violence against others (to any person other than a partner or the children)
- 11. More than one indicator of substance abuse problem: alcohol at index, drugs at index, prior drugs or alcohol, increased drugs or alcohol, more angry or violent, prior offence, alcohol problem, drug problem
- 12. Assault on the victim when she was pregnant
- 13. Victim faces at least one barrier to support: children, no phone, no access to transportation, geographical isolation, alcohol/drug consumption or problem

- **70% of offenders scoring 7 or higher reoffended.**

Risk Assessment Summary

- Risk Assessments should be based on information gathered from multiple sources.
- Risk Assessments should incorporate research-informed instruments as they perform better than "clinical judgement" alone.
- Risk factors for reoffense and risk factors for lethal violence are not the same. Separate instruments should be used.
- Risk assessment findings should specify conditions that might exacerbate risk (e.g., substance abuse, psychiatric problems, unemployment, etc.).
- Risk assessment findings should be shared with "stakeholders".

Screening for Substance Abuse Problems

- Research has shown than substance abuse issues increase risk for treatment failure and reoffense. These problems require special attention.
- Several instruments are useful for screening for substance abuse problems:
  - Substance Abuse Subtle Screening Inventory
  - Addiction Severity Index
  - Michigan Alcohol Screening Test

*A history of DUI or substance abuse-related criminal history indicate the need for more thorough screening and assessment.

SASSI

- The Adult SASSI-3 identifies substance dependence with 93% accuracy
- The SASSI is comprised of face valid items as well as subtle items that do not address substance misuse in a direct or apparent manner.
- The intent of the SASSI is to identify some substance dependent individuals who may be unable or unwilling to acknowledge relevant substance-related behavior (www.sassi.com)

ASI- Alcohol/Drug Items

ALCOHOL/DRUGS
Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
• *Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.*

D1 Alcohol (any use at all)
D2 Alcohol (to intoxication)
D3 Heroin
D4 Methadone
D5 Other Opiates/Analgesics
D6 Barbiturates
D7 Sedatives/Hypnotics/ Tranquilizers
D8 Cocaine
D9 Amphetamines
D10 Cannabis
D11 Hallucinogens
D12 Inhalants
D13 More than 1 substance per day (including alcohol)

http://www.tresearch.org/resources/instruments.htm to obtain instrument and scoring instructions

MAST- Sample Items

- **The MAST Test is a simple, self scoring test that helps assess if you have a drinking problem. Please answer YES or NO to the following questions:**
  1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)
  2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?
  3. Does any near relative or close friend ever worry or complain about your drinking?
  4. Can you stop drinking without difficulty after one or two drinks?
  5. Do you ever feel guilty about your drinking?
  6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
  7. Have you ever gotten into physical fights when drinking?
  8. Has drinking ever created problems between you and a near relative or close friend?
  9. Has any family member or close friend gone to anyone for help about your drinking?
  10. Have you ever lost friends because of your drinking?
- http://www.ncadd-sfv.org/symptoms/mast_test.html

American Society of Addiction Medicine, **Screening, Brief Interventions, and Referral to Treatment-ASAM SBIRT**

- The ASAM criteria identify the following problem areas (dimensions) as the most important in formulating an individualized treatment plan and in making subsequent patient placement decisions
  - **Dimension 1: Acute Intoxication and/or Withdrawal Potential**.
  - **Dimension 2: Biomedical Conditions and Complications**.
  - **Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications**
  - **Dimension 4: Readiness to Change**.
  - **Dimension 5: Relapse, Continued Use or Continued Problem Potential**.
  - **Dimension 6: Recovery Environment**.
- SBIRT--Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.

207

Alcohol Use Disorders Identification Test -AUDIT

- 10-item questionnaire that screens for hazardous or harmful alcohol consumption.
- Developed by the World Health Organization (WHO)
- Correctly classifies 95% of people into either alcoholics or non-alcoholics.
- Free, online at http://www.integration.samhsa.gov/clinical-practice/screening-tools - drugs

208

CAGE Aid

- Commonly used, 5- question tool used to screen for drug and alcohol use.
- The CAGE Assessment is a quick questionnaire to help determine if an alcohol assessment is needed.
- If a person answers yes to two or more questions, a complete assessment is advised.
- Free, online at http://www.integration.samhsa.gov/clinical-practice/screening-tools - drugs

209

Drug Abuse Screen Test-DAST

- 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST and should take less than 8 minutes to complete.
- The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth.
- Free, online at http://www.integration.samhsa.gov/clinical-practice/screening-tools - drugs

210

Behaviors & Attitudes Drinking & Driving Scale-BADDS

- A pre and posttest psychological questionnaire that measures attitudes, behaviors, and intervention effectiveness related to impaired driving.
- **The BADDS can identify:**
  - risk of future impaired driving and riding behaviors
  - intervention effectiveness
  - behavioral and attitudinal change after intervention
  - rationalizations for drinking and driving
  - history of impaired driving

211

Screening for Psychiatric Problems

- Screen for:
  - Prior treatment history
  - Current and past use of psychotropic meds (do not hesitate to recommend a med eval)
  - PTSD

*Instruments such as the Millon Clinical Multiaxial Inventory and Adult Behavioral Checklist can help identify Axis I and II disorders. Axis II disorders can present significant treatment challenges.

Assessing Impact on Children

- DV and Child Abuse frequently co-occur
- Research suggests that in an estimated 30 to 60 percent of the families where either domestic violence or child maltreatment is identified, it is likely that both forms of abuse exist.

Assessing Impact on Children

- Studies show that for victims who experience severe forms of domestic violence, their children also are in danger of suffering serious physical harm.
- In a national survey of over 6,000 American families, researchers found that 50 percent of men who frequently assaulted their wives also abused their children.[8]
- Other studies demonstrate that perpetrators of domestic violence who were abused as children are more likely to physically harm their children.
  - Child Welfare Information Gateway

Assessing Impact on Children

- Some DV risk and assessment instruments ask questions related to children- usually about whether non-biological children are in the home, etc., but don't get directly at the issue of co-occurring abuse.
- Asking the offender to consider the impact his behavior (and if DCFS is or has been involved) is having on the children is a good idea, not only from a child protection perspective but it can open the door to sharing their own child witnessing experiences.

Assess the Client's Suitability for Treatment

- Assessment should inform decisions pertaining to a client's suitability for treatment.
- Suitability issues include dangerousness, medication needs, **substance abuse problems**, developmental disabilities, language and cultural issues, gender and sexual orientation, psychiatric problems, and practical matters such as transportation, work schedule, etc. (Sonkin & Liebert, 2003).
- Programs should address these needs directly or through appropriate referrals.
- Some clients may not be suitable for DV treatment, depending on their needs and the program's approach and resources.

Assessment Should Drive Treatment Planning

- Conducting a thorough, quality assessment is only half the battle. Many programs struggle to "individualize" treatment. A "one-size-fits-all" approach continues to dominate DV treatment.
- Recent meta-analyses suggest that DV programs are, at best, minimally effective, and some may be doing more harm than good (Feder et al., In Press).
- Assessment-driven, individually tailored treatment have been recommended strategies for improving outcomes.

Assessment- Worth the Time

- Sonkin and Leibert (2003) suggest that between 4 and 6 sessions are required to conduct a thorough assessment. Numerous collateral contacts are also usually required.
- Done correctly, assessment can motivate clients to change and improve treatment outcomes.

Risk need responsivity theory

- Based primarily on theories of behavioral psychology
- Intended to support efforts at crime prevention through providing services targeted toward individual "criminogenic" risk factors.

219

Risk-Need-Responsivity Principles

- Risk Principles *Match the level of service to the offender's risk to fail at services/supports/accountability*
- Need Principle *Assess criminogenic needs and target them in treatment*
- Responsivity Principle *Maximize the potential success of rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, abilities and strengths of the offender.*

220

Scientific Support for RNR Principles:

- **Reserve treatment resources for high-risk (high-need offenders) & match risk level to treatment-level**
- Recidivism Study of California's Proposition 36 (Farabee, et al.)
- **Reserve supervision resources for high risk offenders**
- Judicial monitoring in drug court (Marlowe, 2003; Marlowe, 2006)
- **Avoid "over-treating" low-risk (low-need) offenders**
- Canadian study of low-risk offenders under intensive supervision showed double the recidivism (Bonta, Wallace and Rooney, 2000)

http://www.pewstates.org/uploadedFiles/PCS_Assets/2011/Pew_Risk_Assessment_brief.pdf

221

The Risk Principle

- Criminogenic Risk=Prognosis
- The likelihood that an offender will recidivate or fail in mandated interventions/supervision.
- Does not necessarily refer to risk for violence or dangerousness.
- Risk means less amenability to change
- High risk offenders require more intensive **supervision** services
- Mixing offenders with varying risk levels is contraindicated

222

The Need Principle

- Criminogenic Need=Impairment
- Disorder/diagnosis predictive of greater involvement in crime.
- High need offenders require more intensive **treatment** services
- Mixing offenders with varying need levels is contraindicated

223

Different tools serve different purposes:

Example-- DOCCR Validation of Two Domestic Violence Risk Instruments: Domestic Violence Screening Instrument (DVSI) & Spousal Abuse Risk Assessment (SARA) *December, 2010*

- FINDINGS:
  - The DVSI is recommended for use as a risk screening instrument for **risk classification** of domestic violence offenders.
  - The SARA is recommended for **case management** with those offenders classified as **high risk**.

2006 Williams, K. R., and Grant, S. R. Empirically Examining the Risk of Intimate Partner Violence: The Revised Domestic Violence Screening Instrument (DVSI-R). Public Health Rep. July-Aug; 121(4), 400-408.

224

How does Cultural Diversity Impact the Intake and Evaluation Process? --Dialogue--

225

Elements of a DV Offender Evaluation: Obtaining the Victim report/contact

- Signed release of information
- Methods of contact and whether a standardized report or tool is completed
- Contact with Victims Advocate?
- Considering claims that may be biased
- How to interpret the differences between reports
- Whether to make exceptions based on safety
- Safety trumps all. Always.

226

Offender Evaluation Role Play

- Martha--evaluator
- Kent – offender

- Model offender intake and evaluation interview
- Review Offender Evaluation write up and court report
- Questions?

Now it is your turn

- Attendees write up your own evaluation this evening and we will review tomorrow.
- What else do you need to know about the offender?

228

References

Campbell, J.C., Sharps, P.W., & Glass, N. (2000). Risk assessment for intimate partner violence, in Clinical Assessment of Dangerousness: Empirical Contributions, ed. Georges-Franck Pinard and Linda Pagani, New York: Cambridge University Press.

https://www.childwelfare.gov/pubs/usermanuals/domesticviolence/domesticviolenceb.cfm

Feder, L., Wilson, D., & Austin, S. (In Press). A meta-analytic review of court-mandated batterer intervention programs: Can courts affect change? Experimental Criminology.

Hilton, N. Z., Harris, G.T., Rice, M.E., Land, C., Cormier, C.A., & Lines, K.J. (2004). A brief actuarial assessment for the prediction of wife assault recidivism: The Ontario Domestic Assault Risk Assessment. Psychological Assessment, 16 (3), 267-275.

Houghton, A.B., & Williams, K. (2002). Domestic Violence Risk Reduction Project Final Report of Findings. Denver, CO: Colorado Justice Department.

Kropp, P., Hart, R., & Hart, S. (2000). The Spousal Assault Risk Assessment (SARA) Guide: Relability and Validity in Male Offenders. Law and Human Behavior, 24 (1).

Levesque, D.A., Gelles, R.J., & Velicer, W.F. (2000). Development and validation of a stages of change measure for men in batterer treatment. Cognitive Therapy and Research, 24, 175-199.

Miller, S., Duncan, B., & Hubble, M. (1997). Escape from Babel: toward a unifying language for psychotherapy practice. WW Norton: New York.

Miller, W.R., & Rollnick, S. (1991). Motivational Interviewing: Preparing people to change addictive behavior. New York: Guilford Press.

Prochaska, J. O. and C. C. DiClemente (1992). Stages of Change in the Modification of Problem Behaviors. Newbury Park, CA, Sage.

Skilling, N. (2002). Validation study for use of the Domestic Violence Screening Instrument and Spousal Assault Risk Assessment for evaluating probation clients. Hennepin County, MN: Department of Community Corrections.

Sonkin, Daniel and Liebert, Douglas (2003). The assessment of court-mandated perpetrators of domestic violence. Journal of Trauma, Aggression, Maltreatment and Trauma. Volume 6 Number 2, pp 3-36.

Straus, M. A., & Gelles, R. J. (1990). Physical violence in American families: Risk factors and adaptation to violence in 8,145 families. New Brunswick, NJ: Transaction.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996, May). The revised Conflict Tactics Scale (CTS2): Development and preliminary psychometric data. Journal of Family Issues, 17(3), 283-316.

Tollefson, D. R. (2001). *Factors associated with batterer treatment success and failure.* Doctoral Dissertation, University of Utah, Salt Lake City, UT.

Tollefson, D.R., & Gross, E. (In Press). Predicting Recidivism Following Participation in a Treatment Program for Batterers. Journal of Social Services Research.

http://static.nicic.gov/Library/023364.pdf

MODULE IV
BEST PRACTICES IN DV OFFENDER INTERVENTION

Presented by: Rob Butters, LCSW, Phd
Isaac Phillips, LCSW

This Module will support your ability to:

- Use DV Offender Evaluations to Develop effective intervention plans
- Apply the Risk and Needs Principles to Offender Interventions
- Integrate best practices for individual and group treatment services

230

231

Part One--What does the research say about effective offender services?

Presented by: Rob Butters, LCSW, Phd
Director, Utah Criminal Justice Center
University of Utah, College of Social Work

Guiding questions for today:

1. *What do typical DV offender treatment programs look like?*
2. *What is the research on DV offender treatment programs and are these program effective in reducing recidivism?*
3. *What are the characteristics of effective offender treatment programs?*
4. *How can I use the principles of effective programs to improve DV treatment programs?*

Rob Butters PhD LCSW

Overview of common Batterer Intervention Programs

233

- *Duluth Model*
  - *16-50 weeks of group therapy*
  - *Largely psycho educational*
  - *Not usually facilitated by licensed therapists*
- *Derived from Feminist Theory*
  - *Issues of Power and Control*
  - *Patriarchy*
  - *Male Privilege*
  - *Socialization that supports violence against women*
  - *Challenge men's perceived right to dominate their partners,*
  - *Re-educate men to respect women, and to form more egalitarian relationships*
  - *assumes that violent men have deficits in controlling their anger and in their relationship and communication skills.*

(Babcock, Green, & Robie, 2004; Feder & Wilson, 2005; Gondolf, 2007; Stuart, Temple, & Moore, 2007).

Rob Butters PhD LCSW

How effective are DV offender treatment programs?

234

- There are relatively few high-quality evaluations of BIPs that assess violent recidivism.
- Among those studies, BIP has proven to be consistently *ineffective or minimally effective* in curbing abuse
- Babcock, Canady, Graham, & Schart, 2007; Dunford, 2000; Dutton et al., 2003, Feder & Dugan, 2002; Feder & Wilson, 2005; Klein, 2009; Labriola, Rempel, & Davis, 2005.

Rob Butters PhD LCSW

Review of Research on BIPs

235

- A randomized study conducted in Broward, Florida found no significant differences in recidivism between batterers who did and did not have treatment (Jackson et al., 2003b, p.1).
- In addition, there was no indication that those who received treatment modified their attitudes toward DV (Jackson et al., 2003b).
- In another study in Brooklyn, New York, batterers were assigned to one of two experimental groups (8- or 26-week programs) or to a control group. Neither experimental group changed batterers' attitudes toward women or DV (Jackson et al., 2003b).

Rob Butters PhD LCSW

Comparing different treatment programs

236

- Two meta-analyses indicate either a small deterrent effect or no effect (Babcock et al., 2004; Feder & Wilson, 2005).
- Furthermore, several studies have now found no matter whether the BIP program has a feminist, psycho-educational, cognitive-behavioral, or has elements of all three philosophies, it does not or only minimally reduces IPV (Babcock et al., 2004; Dunford, 2000; Gondolf & Jones, 2001).

Rob Butters PhD LCSW

WSIPP Study

237

- Meta-analyzed existing literature on group DV treatment
- Of 34 published studies, only 9 met inclusion criteria
  - Must have comparison group (quasi experimental, RCT, or statistical controls).
  - Excluded studies that did not include data on drop-outs/non completers. (ITT addresses that)
- Studies yield 11 effect sizes
- Sorted by Duluth-like and other treatment models

Rob Butters PhD LCSW

Exhibit 1
Studies of DV Offender Group Treatment Included in the Meta-Analysis

Study	Location	Treatment Type	Treatment N	Duration	Comparison	Effect Size (p-value)* DV recidivism	Any recidivism
Davis et al., 2000a	Brooklyn	Duluth model	129	40 hrs over 26 wks	40 hr community service	-0.447 (p=0.01)**	N/A
Davis et al., 2000b	Brooklyn	Duluth model	61	40 hrs over 8 wks	40 hr community service	-0.091 (p=0.67)	N/A
Dunford, 2000a	San Diego Naval Base	Cognitive-behavior, focus on relationships, communication, empathy.	168	26 weekly sessions followed by 6 monthly sessions	No treatment	-0.066 (p=0.85)	N/A
Dunford, 2000b	San Diego Naval Base	Couples group therapy	153	26 weekly sessions followed by 6 monthly sessions	No treatment	-0.269 (p=0.50)	N/A
Easton et al., 2007	New Haven	Substance abuse treatment	29	12 weekly sessions	12-step program	-0.317	N/A
Feder, 2000	Broward County	Duluth model	227	26 weekly sessions	Probation only	-0.113 (p=0.68)	+0.320 (p=0.02)
Gordon, 2003	Virginia	Duluth model	132	20 or 24 wks	Probation only	+0.219 (p=0.20)	N/A
Harrell, 1991	Baltimore	Mixed, 82% were Duluth model	81	Varied 8 to 18 wks	Probation only	+0.490 (p=0.054)	N/A
Labriola et al., 2008	Bronx	Duluth model	173	26 weekly sessions	Probation only	+0.237 (p=0.12)	+0.089 (p=0.51)
Palmer et. al., 1992	Ontario Canada	Cognitive-behavioral, client-centered, focus on understanding violence, coping with conflict, self-esteem, relationships with women	30	10 weekly sessions	Probation only	-0.835 (p=0.06)	N/A
Waldo, 1988	East Coast US	Relationship enhancement therapy	60	12 weekly sessions	No treatment	-0.487 (p=0.20)	N/A

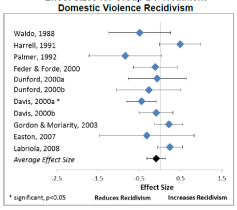
238

WSIPP (2013)

239

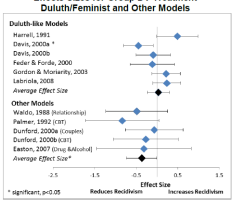
Combined DV Recidivism

Effect Sizes for Group DV Treatment
Domestic Violence Recidivism



Duluth (no effect) vs. Other (33% reduction in DV)

Effects Sizes for Group DV Treatment
Duluth/Feminist and Other Models



Rob Butters PhD LCSW

Promising DV Programs

240

- Multi-Couples therapy (Stith, 2003, 2004, 2007)
  - Targets interpersonal dynamics
  - Addresses social desirability issues
  - But…Conjoint treatment is prohibited by statute until after 12 sessions of BIP
  - Most treatment providers shy away from couples work
- EMERGE
  - Based on cognitive and social learning principles
  - But…no rigorous evaluation to date
- MRT
- T4C
- Mind-body Bridging

Rob Butters PhD LCSW

Most recent research on BIPs

241

- Mills, Barocas, Ariel (2012). The next generation of court-mandated domestic violence treatment: a comparison study of batterer intervention and restorative justice programs. *Journal of Experimental Criminology* 9(1), 65-90.
- Most rigorous study to-date on DV interventions
  - 2-year RCT
  - Found no significant reduction of DV recidivism
  - Found no difference between BIP and Circles of Peace
  - Offenders in BIP had slightly higher non-DV recidivism

Rob Butters PhD LCSW

Characteristics of Effective Programs

Lowencamp, Latessa, & Smith (2006), Andrews & Bonta (2010)

242

The term "what works" means that evidence exists that the program or intervention is effective in reducing recidivism.

Effectiveness is demonstrated through empirical research – not stories, anecdotes, common sense, or personal beliefs about effectiveness.

Evidence strongly indicates that TREATMENT is more effective in reducing recidivism than PUNSIHMENT. *But Not All Treatment Programs Are Equally Effective*

Absent rigorous outcome research on a given program we can evaluate a program using the principles of effective interventions.

Rob Butters PhD LCSW

Characteristics of Evidence-Based Programs

- Risk Principle (WHO)– Primary Focus on HIGH Risk
- Need Principle (WHAT) – Target Criminogenic Needs
- Treatment Principle (HOW) – Use Behavior Approaches
- Responsivity (HOW) – Ability and Capacity to Match Behavior Treatment to offender Needs
- Program Integrity (HOW WELL) - Ensure quality Implementation and Improvement

Gendreau, P., French, S. A., & Gionet, A. (2004). What works (what doesn't work): The principles of effective correctional treatment. *Journal of Community Corrections, 13, 4-6,* 22-30.

Overview of the Correctional Program Checklist (CPC)

- Developed at University of Cincinnati
- Based on the "what works" literature- based on evidence (i.e., the results of meta-analytic reviews)

  - based on the collective experience of authors and associates
- Based on the results of over 400 evaluations and three large outcome studies conducted by the University of Cincinnati Criminal Justice Center (40,000 Offenders)
- 77 items for a possible score of 0-83
  - HIGHLY EFFECTIVE (65% to 100%);
  - EFFECTIVE (55% to 64%);
  - NEEDS IMPROVEMENT (46% to 54%); or
  - INEFFECTIVE (45% or less).

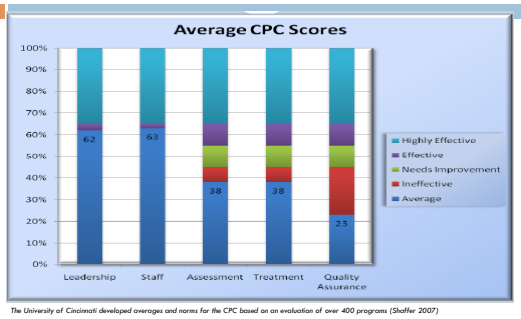
CPC – Areas of Assessment

- Content
  - Offender Assessment – Risk and Needs
  - Treatment Characteristics – CBT, Social Learning
- Capacity
  - Program Leadership - Responsivity
  - Staff Characteristics - Responsivity
  - Quality Assurance and Improvement

Components of the CPC Evaluation

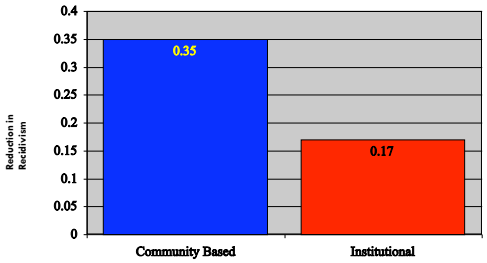
- Staff survey of experience, education, and training
- Structured interviews with program director and staff using evaluation questionnaire
- Program file review
- Program participant interviews
- Group observation assessment
- Family interviews
- Review of assessment instruments and scoring guide

Average CPC Scoring



The University of Cincinnati developed averages and norms for the CPC based on an evaluation of over 400 programs (Shaffer 2007)

Community Based versus Institutional Programs: Results from Meta-Analyses of Programs Based on Principles of Effective Treatment

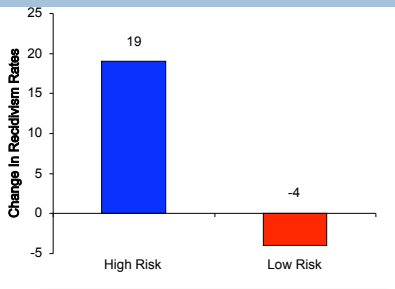


Source: Gendreau, P., French, S.A., and A. Taylor (2002). What Works (What Doesn't Work) Revised 2002. Invited Submission to the International Community Corrections Association Monograph Series Project.

Risk Principle

1. Target those offenders with higher probability of recidivism
2. Provide most intensive treatment to higher risk offenders
3. Intensive treatment for lower risk offender can increase recidivism

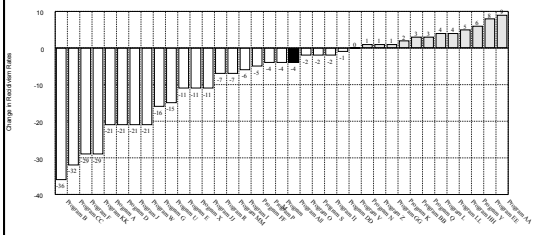
The Risk Principle & Correctional Intervention Results from Meta Analysis



Dowden & Andrews, 1999

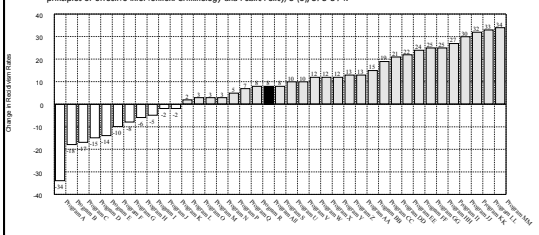
Risk Principle – Ohio Study of Low Risk Offenders

Lowenkamp, C. T., Latessa, E. J., & Smith, P. (2006). Does correctional program quality really matter? The impact of adhering to the principles of effective intervention. *Criminology and Public Policy, 5* (3), 575-594.



Risk Principle – Ohio Study of High Risk Offenders

Lowenkamp, C. T., Latessa, E. J., & Smith, P. (2006). Does correctional program quality really matter? The impact of adhering to the principles of effective intervention. *Criminology and Public Policy, 5* (3), 575-594.



RECAP—How do we use an Offender Evaluation to drive Offender Services?

1. To identify risk of recidivism
2. To identify appropriate offenders for programs
3. To identify criminogenic needs
4. To identify factors that can affect program success
5. To provide risk & need levels that will facilitate development of case plan
6. To facilitate reassessment of offender to determine which risk & need factors have changed

Evaluations and Services Based on Criminogenic Needs (Big 4)

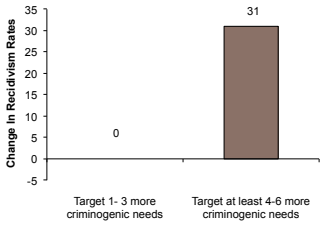
1. Antisocial Behavior: Exploitive, aggressive, or harmful behavior toward others
2. Antisocial Personality Pattern: Impulsive, sensation seeking, risk-taking, aggressive, manipulative and exploitive.
3. Antisocial Cognition: Values, beliefs, and cognitions that contribute to personal identity that favors criminal behavior.
4. Antisocial Peers

Criminogenic Needs (moderate 4)

5. Family: Chaotic and poor-quality family relationships that have minimal or no pro-social expectations.
6. School/Work: Poor performance and limited engagement with school or work
7. Leisure & Recreation: Limited involvement in anti-criminal leisure activities.
8. Substance Abuse: Use and abuse of alcohol, tobacco, or other drugs (ATOD).

Need Principle and Correctional Intervention

Lowenkamp, C.T., Pealer, J., Smith, P., & Latessa, E.J. (2006). Adhering to the risk and need principles: Does it matter for supervision-based programs? *Federal Probation, 70* (3), 3-8.

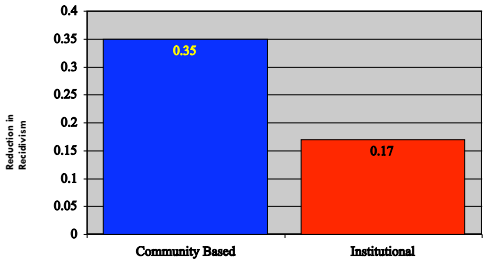


Criminogenic Need	Treatment Targets
Antisocial Behavior Explosive, aggressive, or harmful behavior toward others	Increase pro-social behaviors by reinforcing prosocial beliefs supporting a crime-free lifestyle. Develop clear, consistent, and proximate reward and consequence system for addressing behaviors. Teach, model, and reinforce pro-social alternative behaviors, especially in high-risk situations.
Antisocial Personality Pattern Impulsive, sensation seeking, risk-taking, aggressive, manipulative and exploitive.	Treatment target: increase self-control and delayed gratification skills, anger and conflict management, problem solving and reinforce prosocial, reciprocal interpersonal interactions.
Antisocial Cognition Values, beliefs, feelings, and cognitions that contribute to personal identity that favors and reinforces criminal behavior.	Address cognitive distortions and rationalizations that maintain a criminal identity. Build, practice, and reinforce new cognitions and attributions that lead to positive outcomes through cognitive restructuring and cognitive-behaviors therapies.
Antisocial Peers Performing to associate with pro-criminal peers and isolation from anti-criminal peers and social contexts.	Reduce and eliminate association with delinquent peers and increase opportunities for regular association with anti-criminal peers and institutions (school, church, clubs, sports teams, and other structured and supervised activities).
Family Chaotic and poor-quality family relationships that have minimal or no pro-social expectations regarding crime and substance abuse.	Increase pro-social communication, nurturance, structure, supervision, and monitoring in the family. Address dysfunctional boundaries and role confusion. Implement behavioral management system that provides for consistent rewards for pro-social family interactions.
School/Work Poor performance and limited engagement with school or work resulting in dissatisfaction and avoidance of these institutions.	Increase school engagement and performance in work and school though remediation of barriers to satisfaction i e. Individualized Education Plan, additional job training or alternate job placement. Implement monitoring and behavioral reinforcement program to increase consistent attendance at school and work.
Leisure & Recreation Limited involvement in anti-criminal leisure activities.	Expose youth to a variety of pro-social leisure and recreational activities. Increase opportunities for regular involvement in preferred activities and reward milestones in achievement.
Substance Abuse Use and abuse of alcohol, tobacco, or other drugs (ATOD).	Reduce substance use through targeted treatment, increase supervision and reduce access to ATOD, and reduce exposure to ATOD using peers. Increase capacity to cope with stressors though lifestyle changes like regular exercise, sleep, and nutrition.

257

Butters, R. P. (2014) *Community Based Treatment Interventions.* In W. Church & D. Springer (Eds.), Juvenile Justice Sourcebook. New York, NY: Oxford University Press.

Community Based versus Institutional Programs: Results from Meta-Analyses of Programs Based on Principles of Effective Treatment



Source: Gendreau, P., French, S.A., and A. Taylor (2002). What Works (What Doesn't Work) Revised 2002. Invited Submission to the International Community Corrections Association Monograph Series Project.

Treatment Principle

The most effective interventions to change *behaviors* are…

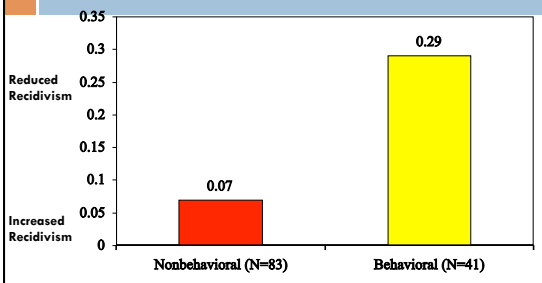
Grounded in Behavioral therapy *(and enhanced by cognitive interventions)*

1. Focus on current factors that influence behavior
2. Action oriented-role plays, experiential, practice
3. Offender behavior is appropriately reinforced
   a. Effective use of rewards and punishers

Most Effective Models

- Structured social learning where new skills and behavioral are modeled
- Cognitive behavioral approaches that target criminogenic risk factors
- Family based approaches that train family on appropriate techniques

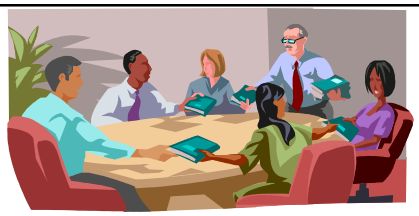
Behavioral vs. NonBehavioral



Andrews, D.A. 1994. An Overview of Treatment Effectiveness. Research and Clinical Principles, Department of Psychology, Carleton University. The N refers to the number of studies.

The Four Principles of Cognitive Intervention

1. Thinking affects behavior
2. Antisocial, distorted, unproductive irrational thinking causes antisocial and unproductive behavior
3. Thinking can be influenced
4. We can change how we feel and behave by changing what we think



Social Learning

Refers to several processes through which individuals acquire attitudes, behavior, or knowledge from the persons around them. Both modeling and instrumental conditioning appear to play a role in such learning

Evidence-based Group Treatment

264

1. Facilitator provides a brief background on target behavior(s), i.e. violence, substance use, family discord (this could be place to use an engaging video clip, other media, or current event).
2. Identify the underlying thoughts, feelings, cognitions that are associated with the dysfunctional behavior.
3. Identify thoughts are dysfunctional, cognitive distortions, or misattributions.
4. Explore alternative thoughts/attributions and explore feeling associated with those options
5. Identify healthy thinking and behavioral alternatives
6. Facilitator models prosocial thinking and resulting behaviors for group
7. Participants role play real scenario while being directly observed by facilitator
8. Facilitator provides positive reinforcement for successes, provides feedback for improvement.
9. Participants continue to practice until skill, in increasingly challenging scenarios, until mastered.
10. Participants are provided "homework" to practice skill at home or school and report back to group on successes and challenges.

Butters, R. P. (2014) *Community Based Treatment Interventions.* In W. Church & D. Springer (Eds.), Juvenile Justice Sourcebook. New York, NY. Oxford University Press.

Rob Butters PhD LCSW

Ineffective Approaches

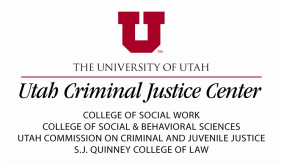
- Psychoeducation
- Shaming offenders
- Non-directive, client centered approaches
- Gestalt
- Bibliotherapy
- Freudian approaches
- Self-Help programs
- Vague unstructured rehabilitation programs
- Medical model
- Fostering self-regard (self-esteem)

Responsivity: Interventions should match the uniqueness of the offender

- Culture
- Gender
- Trauma
- Learning/cognitive disability
- Motivation
- Reading ability
- Personality characteristics
- Mental Health

Thank you!

267



Rob.butters@utah.edu

Office: 801 585-3246

PART TWO: APPLYING BEST PRACTICES IN OFFENDER SERVICES

Presented by: Isaac Phillips, LCSW
Equinox Counseling

UNIQUE ELEMENTS DV OFFENDER INTERVENTION

COURT-ORDERED OFFENDER TREATMENT DIFFERS FROM TRADITIONAL PSYCHOTHERAPY.

- Treatment is not voluntary. The offender enrolls in treatment at the Court's direction and sanctions will be applied for failure to participate.
- The offender must receive evaluation and intervention services only from treatment providers licensed by the state.
- Treatment goals are chosen by the provider, in relation to the individual needs of the offender, to meet the overall ends of reducing recidivism and increasing victim and community safety.
- #1 Priority is victim safety
- Treatment goals are not client-driven
- Confidentiality is held to the highest standard for victims

UNIQUE ELEMENTS DV OFFENDER INTERVENTION

COURT-ORDERED OFFENDER TREATMENT DIFFERS FROM TRADITIONAL PSYCHOTHERAPY.

- Confidentiality- minimal (offender)
- Providers are required to have a professional relationship with victim advocates
- Advocate does outreach to victim, resource referral, and conveys victim's perspectives
- Treatment is cognitive behavioral, educational, experiential
- Minimum of 16 weeks, can be longer depending on offender risk, progress, victim safety
- Identify other clinical issues (i.e. substance abuse, mental health) and create comprehensive treatment plans

OBJECTIVES OF DV OFFENDER INTERVENTION

The Offender - Accepts responsibility for battering, assaulting, and/or threatening behavior.

- Learns why violence is used to solve problems.
- Understands and applies processes necessary to change behavior.
- Increases constructive expressions of emotions, replacing abusive and coercive strategies.
- Learns and applies safe communication methods, listening skills, and anger control.
- Dynamics of healthy relationships – Self-Referential vs. Comprehensive/Empathetic

OBJECTIVES OF DV OFFENDER INTERVENTION

The Offender - Improves self-control, providing a safe space in relationships

- Decreases isolation and develops positive support systems.
- Understands the inter-generational aspects of abuse and family violence.
- Elicits commitments to end violent behavior in intimate and familial relationships.
- Learns alternative strategies to resolving conflicts within intimate and familial relationships.

IS WHAT I AM DOING

SAFE FOR THE VICTIM?

THE PROVIDER-CLIENT DYNAMIC

Potentially unsafe practices-compromising victim safety

- Reading police reports, particularly the victim account, to the individual perpetrator, or to the group may place the victim in danger for obvious reasons.
- Do not share any victim information with the perpetrator, i.e. victim contact information, safety planning, reports of continued abuse while the perpetrator is in treatment, etc.
- **Assume the offender does not have the information about the victim**
- Perpetrator assessments should not be performed in the presence of the victim (or anyone else)

THE PROVIDER-CLIENT DYNAMIC

Potentially unsafe practices- compromising victim safety

- Do not invite the victim to perpetrator group; if couples treatment is deemed appropriate after the mandated 12 sessions, the couple should not attend group together.
- Do not validate, **minimize** or condone any aggressive behavior to build rapport (or any other reason) with the perpetrator; this may validate the perpetrators behavior and reduce their personal accountability (and fuel further abuse).

THE PROVIDER-CLIENT DYNAMIC

The perpetrator is in treatment, not the victim

- Do not encourage the perpetrator to "teach" the victim skills he/she is learning; this would put the perpetrator in a position of authority (in fact, reinforce this point).
- Do not agree or recommend to the perpetrator that the victim should also be in treatment.
- Do not validate that the victim is the problem, it will take away from accountability and add to victim blaming.

THE PROVIDER-CLIENT DYNAMIC

Accountability while maintaining the therapeutic alliance

- Importance of each
- The role of the treatment provider
- Professional Boundaries
- Empathy
- Transference and Counter Transference
- Know Thyself
- What you might experience
- Ongoing supervision/consultation/support

THE PROVIDER-CLIENT DYNAMIC

Professional Boundaries

- Understand the risks for therapists and develop a safety plan.
- Do not treat the perpetrator as if they are horrible, avoiding empathy/compassion.
- Don't disagree openly with the decisions of the police/judge/ prosecutor/probation officer/etc.
- Maintain professional boundaries if client is encountered outside the therapeutic environment. Think this scenario through *before* you have this experience.

THE PROVIDER-CLIENT DYNAMIC
ADDRESSING CLIENT'S NEGATIVE COPING STRATEGIES IN REAL TIME

Self-Victimization:

- Blaming
- Complaining
- Threatening
- "Isolated" incident
- Minimizing/ Denying

Venting:

- risks and benefits
- appropriate uses
- how to reframe inappropriate uses

THE PROVIDER-CLIENT DYNAMIC

Intimate Partner Relationships

- Power/control-violence/Aggression/ Abuse
  - What does it look like?
  - What drives it?
- Conflict dynamics
- High-conflict couples
- Intimate vs. Non-Intimate

250

PRINCIPLES OF DV OFFENDER INTERVENTION

Intake and Assessment are critical

Treatment is meant to create opportunities for change and addresses the offender's:

- Accountability (or lack of)
- Denial
- Minimization
- Cognitive deficits and disabilities/ Destructive belief systems

RESPONSIBILITY FOR CHANGE RESTS WITH THE OFFENDER

251

PRINCIPLES OF DV OFFENDER INTERVENTION

Minimization and denial of the need for treatment is expected and therefore a therapeutic alliance is not a prerequisite for treatment. ,Treatment involves the challenging of the offender's perceptions and beliefs.

Psycho-education includes:

- Dynamics of domestic violence
- Types of abuse
- Effects on children
- Effects on victims
- Offender self-management techniques
- Healthy relationship dynamics

RESPONSIBILITY FOR CHANGE RESTS WITH THE OFFENDER

252

DV TREATMENT VS. ANGER MANAGEMENT

DV offender treatment differs greatly from anger management classes.

Anger management can be one small component of DV treatment, but it is NOT the focus of treatment. (All people experience anger but we do not all choose to use abuse and violence toward a partner.)

DV offender treatment addresses such things as:

-Power and control issues of the offender

-Accountability of the offender for the abusive acts

-Identification of abusive behaviors and destructive beliefs systems of the offender

-Addresses coercive behaviors, denial, blaming, and minimization

-Promotes and creates opportunities for learning healthy attitudes, behaviors, coping skills, and relationship skills

Responsibility for change rests with the offender

253

ENGAGEMENT, DOCUMENTATION

ETHICAL CONSIDERATIONS, DIALOGUE/Q&A, REVIEW

TEST (LINK)
COMPLETE ON SURVEY MONKEY. COMPLETION CERTIFICATES WILL BE MAILED AFTER THE TEST HAS BEEN SUCCESSFULLY COMPLETED (80% OR BETTER).

254

ETHICAL CONSIDERATIONS FOR CLINICIANS SERVING DV OFFENDERS

- Should interns and supervised providers conduct services independently?
- What is "specialized" DV training?
- How do we handle court or media requests for client information?
- Mandatory reporting standards

255

NEW DIRECTIONS IN DV TREATMENT

- Risk and need determines intensity/duration of treatment
- Low, moderate and high risk offenders are treated uniquely
- Levels of treatment that are differentiated by intensity of contact and content
- Offender competencies are assessed throughout
- Discharge criteria
- Multi-disciplinary treatment team

256

REMEMBER LETHALITY RISK IS REAL

CAMPBELL LETHALITY RISK STUDY, JOHNS HOPKINS UNIVERSITY 2003-2010:

- 67-80% of intimate partner homicides involve physical abuse of the female by the male before the murder.
- 85% of intimate partner homicide victims were stalked prior to their murder
- Risk of intimate partner femicide was increased nine times when the abuser was highly controlling and the couple separated after living together.
- Previous arrest of the abuser for domestic violence was associated with a *decreased risk* of intimate partner femicide.
- Previous threats with a weapon were associated *with increased risk of intimate partner femicide*.
- Abuser's use of a gun in the worst incident of abuse was associated with a 41-fold increase in risk of femicide
- 83% of women killed by intimate partners were receiving DCFS services at the time
- Over 10,000 children witness intimate partner murders each year; 80 PER YEAR IN UTAH.

257

THE KEY TO BREAK THE CYCLE OF VIOLENCE

Preventing Risk and Promoting Protective Factors *Throughout the Lifespan:*

Plasticity occurs throughout our lifespan, with large areas of brain development in childhood and adolescence

Stabilizing the lives of adults improves the environment in which children grow and learn

Module V

Review and certification

289

Emergency Resources

Anonymous and Confidential Help 24/7

- Utah Domestic Violence Link Line **1-800-897-LINK** (5465)
- Utah Rape and Sexual Assault Crisis Line **1-888-421-1100**
- The National Domestic Violence Hotline **www.thehotline.org 1-800-799-SAFE** (7233) **1-800-787-3224** (TTY)

290

Where can I turn for additional support?

Contact your County Commissioner- To determine who your local county commissioner is, click here: http://www.utah.gov/government/countymap.html

Division of Child and Family Services- provides statewide domestic violence services, not only to victims and families with DCFS involvement. 801.419.8779

Division of Substance Abuse and Mental Health-ensuring that prevention and treatment services for substance abuse and mental health are available statewide. 801.538.3939 http://www.dsamh.utah.gov/locationsmap.htm

Utah Association of Domestic Violence Treatment-non-government association of mental health professionals with expertise in the therapeutic assessment and treatment of victims, children, and perpetrators of domestic violence. http://uadvt.org/

Where can I turn for additional support?

Utah Domestic Violence Coalition-nationally recognized for expertise in victim advocacy, a non-profit organization serving as an information clearinghouse and resource center for the state and supporting collaboration with governmental systems. www.udvc.org

The LINK line-- a state-wide confidential hotline where callers can receive crisis intervention, safety planning, information and referral services on safe shelters, community resources, legal assistance, victim advocates, counseling agencies and other needs. All calls are answered by trained domestic violence specialists. The LINKLine operates 24 hours a day 7 days a week. **1-800-897-LINK (5465)**

Utah Commission on Criminal and Juvenile Justice--coordinates criminal and juvenile justice policy among the branches and levels of government. http://www.justice.utah.gov/

Crime Victim Reparations/The Utah Office for Victims of Crime (UOVC)- provides financial compensation for victims of crime, administers and monitors Victim of Crime Act Compensation and Assistance grants and Violence Against Women grants, networks victim services across the state, provides enhanced training. www.crimevictim.state.ut.us/

292

References and more resources

- U.S. Department of Health and Human Services, SAMHSA, OAS. 2009
- Utah Commission on Criminal and Juvenile Justice. No More Secrets – Utah's Domestic and Sexual Violence Report, 2012. Available at: http://nomoresecrets.utah.gov/Annual%20Reports/nms_annualreport_2012.pdf
- Academy on Violence and Abuse. Consequences of Lifetime Experiences of Violence and Abuse – The COLEVA Project. 2009. Available at www.avahealth.org
- Black MC et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2011. Available at: http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf
- Carter LS et al. Domestic violence and children: Analysis and recommendations. The Future of Children –Domestic Violence and Children. 1999;9:420
- Catalano S. Special Report--Intimate partner violence, 1993-2010. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, NCJ 239203; 2012.

References and more resources

- Feder, L.,Wilson, D., & Austin, S. (2008). Court-Mandated Interventions for Individuals Convicted of Domestic Violence. Campbell Systematic Reviews (12), 1-49.
- Felitti VJ et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults—the Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998;14:245-258
- Gondolf, E. (2004). Evaluating Batterer Counseling Programs: A Difficult Task Showing Some Effects and Implications. Aggression and Violent Behavior, (9), 605-631.
- Institute of Medicine of the National Academies. *Clinical Preventive Services for Women—Closing the Gaps.* 2011. The National Academies Press, Washington DC.
- Miller, M., Drake, E., & Nafziger, M. (2013). *What works to reduce recidivism by domestic violence offenders?* (Document No. 13-01-1201). Olympia: Washington State Institute for Public Policy.
- *Trauma Informed Advocacy Tipsheets*, National Center for Trauma, Mental Health, and Domestic Violence, 2012.
- *Homeostasis, Stress, Trauma, and Adaptation: A Neurodevelopmental View of Childhood Trauma;* Bruce D. Perry, MD, Ph.D, and Ronnie Pollard, MD

References and more resources

- Adams, D. (2003). Treatment programs for batterers. *Clinics in Family Practice, 5*(1), 159-176.
- Andrews, D. A., & Bonta, J. (2010). The Psychology of Criminal Conduct. Newark, NJ: Anderson Publishing Co.
- Babcock, J. C., Canady, B., Graham, K. H., & Schart, L. (2007). The evolution of battering interventions: From the dark ages into the scientific age. In J. Hamel & T. Nicholls (Eds.), *Family Therapy for Domestic Violence: A Practitioner's Guide To Gender-Inclusive Research and Treatment* (pp. 215–244). NY: Springer.
- Babcock, J.C., Green, C.E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review*, 23(8), 1023-1053.
- Berk, R.A. (1993). What the scientific evidence shows: On the average, we can do no better than arrest. In K.J. Gelles & D.R. Loeske (Eds.), *Current controversies on family violence* (pp. 323-336). Newbury Park, CA: Sage.
- Billingham, R.E., & Sack, A. R. (1987). Conflict tactics and the level of emotional commitment among unmarrieds. *Human Relations, 40*, 59-74.
- Brannen, S., & Rubin, A. (1996). Comparing the Effectiveness of Gender-Specific and Couples Groups in a Court-Mandated Spouse Abuse Treatment Program. *Research on Social Work Practice, 6*(4), 405-424.
- Bridges S.F., Tatum K.M., & Kunselman J.C. (2008). Domestic violence statutes and rates of intimate partner and family homicide: A research note. *Criminal Justice Policy Review, 19*(1), 117-130.
- Busch, A.L., & Rosenberg, M.S. (2004). Comparing women and men arrested for domestic violence: A preliminary report. *Journal of Family Violence, 19*(1), 49-57.

References and more resources

- Cecala, S., & Walsh, M. M. (2006). *New York State's Response to Domestic Violence: Systems and Services Making a Difference.* Office for the Prevention of Domestic Violence.
- Catalano, S. (2006). Intimate Partner Violence in the United States, U.S. Department of Justice, Bureau of Justice Statistics. Web site: http://www.ojp.usdoj.gov/bjs.
- Catalano, S., Smith, E., Snyder, H., & Rand, M. (2009). Bureau of Justice Statistics selected findings: Female victims of violence. Washington, DC: U.S. Department of Justice.
- Cho, H. & Wilke, D. J. (2010). Does police intervention in intimate partner violence work? Estimating the impact of batterer arrest in reducing revictimization. *Advances in Social Work, 11(2),* 283-302.
- Corvo, K., Dutton, D., & Chen, W.Y. (2008). Toward evidence-based practice with domestic violence perpetrators. *Journal of Aggression, Maltreatment, and Trauma, 16*(2), 111-130.
- Corvo, K., Dutton, D., & Chen, W.Y. (2009). Do Duluth model interventions with perpetrators of domestic violence violate mental health professional ethics? *Ethics & Behavior,* 19(4), 323 – 340.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241-1299.