AFTER PUBLIC COMMENT REVIEW BY THE STANDARDS REVISION COMMITTEE (SRC), NO CHANGES WERE MADE TO SECTION 5.01.

AFTER PUBLIC COMMENT REVIEW BY THE SRC, NO CHANGES WERE MADE TO SECTION 5.02.

AFTER PUBLIC COMMENT REVIEW BY THE SRC, PROPOSED NEW LANGUAGE WAS

CREATED AND IS CAPITOLIZED AND BOLDED IN THIS DOCUMENT.

5.03 Implementation of Individualized Treatment Plan

A provider who treats domestic violence offenders under the jurisdiction of the criminal legal system must use domestic violence offender treatment (see Definition Section). Providers shall develop an individualized treatment plan that is formulated based on the client RISK and needs, evaluation recommendations, and the core treatment competencies. The individualized treatment plan may incorporate adjunct services that address ongoing or emerging co-occurring issues. The individualized treatment plan shall identify treatment goals for the client in order to promote victim and community safety.

I. Individualized Treatment Plan

Upon a client entering treatment, a provider shall develop a written treatment plan based on the relevant risks and needs identified in current and past assessments/evaluations of the client. The process shall be guided by the treatment provider and developed through collaboration with the client. The Treatment Plan shall:

- Promote victim and community safety.[1]
- Promote client engagement through motivational enhancement strategies.[2]
- Identify the behaviors mandating treatment and specifically address all clinical issues outlined in the intake evaluation and via validated risk assessment.[3]
- Include measurable treatment goals that address protective and risk factors consistent with the client's treatment needs, competency and ability.[4]
- Include planning for and referral to adjunct treatment as indicated.[5]

[1] § 16-11.8-101 C.R.S. includes reference to enhancing the protection of current victims and potential victims. [2] Santirso, F. A., Gilchrist, G., Lila, M., & Gracia, E. (2020). Motivational strategies in interventions for intimate partner violence offenders: A systematic review and meta-analysis of randomized controlled trials. Psychosocial Intervention, 29(3), 175-190.

[3] Friedman, B. D., Yorke, N. J., Compian, K., & Arner Lazaro, D. (2022). A multimodal approach to reduce attrition, recidivism, and denial in abuser intervention programs. Journal of Offender Rehabilitation, 61(8), 426–441; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. Psychological Services, 18(4), 566–573; Radatz, D. L., Richards, T. N., Murphy, C. M., Nitsch, L. J., Green-Manning, A., Brokmeier, A. M., & Holliday, C. N. (2021). Integrating 'principles of effective intervention' into domestic violence intervention programs: New opportunities for change and collaboration. American Journal of Criminal Justice, 46, 609-625. [4] Burghart, M., de Ruiter, C., Hynes, S. E., Krishnan, N., Levtova, Y., & Uyar, A. (2023). The Structured Assessment of Protective Factors for violence risk (SAPROF): A meta-analysis of its predictive and incremental validity. Psychological Assessment, 35(1), 56–67; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. Psychological Services, 18(4), 566–573; Radatz, D. L., Richards, T. N., Murphy, C. M., Nitsch, L. J., Green-Manning, A., Brokmeier, A. M., & Holliday, C. N. (2021). Integrating 'principles of effective intervention' into domestic violence intervention programs: New opportunities for change and collaboration. American Journal of Criminal Justice, 46, 609-625.

[5] Radatz, D. L., Richards, T. N., Murphy, C. M., Nitsch, L. J., Green-Manning, A., Brokmeier, A. M., & Holliday, C. N. (2021).

Integrating 'principles of effective intervention' into domestic violence intervention programs: New opportunities for change and collaboration. American Journal of Criminal Justice, 46, 609-625.

- Be written in a way that is understandable to the client in consideration of the client's responsivity factors.[6]
- Be reviewed with the client and the MTT at a minimum of every 2-3 months, referred to as Treatment Plan Reviews.[7]
- **ORIENT THE CLIENT TO THE PURPOSE AND NEED FOR TREATMENT PLAN REVIEWS**

II. Core Treatment Competencies

Domestic violence offender treatment shall help clients develop competencies (that is, knowledge, skills, and attitudes) to effectively address their risk-related problems, develop protective factors, establish non-abusive relationships, and lead non-offending lives. The required competencies shall be facilitated for all clients. The potential competencies may be included for clients when clinically indicated. The required and potential competencies are not an exhaustive list of all potential competencies needing to be addressed in treatment. As such, Approved Providers may include additional competencies to address risk factors and individual treatment needs, where needed and indicated in the treatment plan. The list of competencies is not set forth in a linear curriculum order nor as a prioritized list of behavioral goals. Instead, the competencies may be addressed in an order consistent with the treatment plan, the needs of the client, the order of group treatment sessions, or across multiple aspects of treatment. Assisting clients to achieve the competencies in their treatment plan shall be the basis for prioritizing ongoing and subsequent second contact requirements in accordance with the treatment level of the client.

Domestic Violence and General Criminality

Clients shall meet the following required competencies related to Domestic Violence and General Criminality:

1. Define all types of domestic violence and abusive behavior (reference working clinical definition of domestic violence) and demonstrates acceptance of accountability and responsibility for offending and abusive behaviors.[8]

2. Identify the history of current and former patterns of domestic violence behaviors and thoughts regarding onset, frequency, and persistence. This includes awareness and discuss the intent of previous grooming tactics.[9]

   Discussion Point: *Clients may invoke their 5th Amendment right for current or pending cases. While Approved Providers shall not unsuccessfully discharge an offender from treatment solely for refusing to answer incriminating questions, a treatment provider may opt to discharge a client from treatment or not accept a client into treatment if the provider determines a factor(s) exists that compromises the therapeutic process.*

[6] Radatz, D. L., Richards, T. N., Murphy, C. M., Nitsch, L. J., Green-Manning, A., Brokmeier, A. M., & Holliday, C. N. (2021). Integrating 'principles of effective intervention' into domestic violence intervention programs: New opportunities for change and collaboration. American Journal of Criminal Justice, 46, 609-625.

[7] § 16-11.8-101 C.R.S. includes reference to monitoring of offenders.

[8] Gannon, T. A., Olver, M. A., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review, 73*; Hilton, N. Z., Eke, A. W., Kim, S., & Ham, E. (2023). Coercive control in police reports of intimate partner violence: Conceptual definition and association with recidivism. *Psychology of Violence, 13*(4), 277–285; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence, 29*, 151-164.

[9] Gannon, T. A., Olver, M. A., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review, 73*; Hilton, N. Z., Eke, A. W., Kim, S., & Ham, E. (2023). Coercive control in police reports of intimate partner violence: Conceptual definition and association with recidivism. *Psychology of Violence, 13*(4), 277–285; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence, 29*, 151-164.

3. Identify and challenge cognitive distortions and belief systems that plays a negative or unhealthy role in the

client's thoughts, emotions, and behaviors.[10]

Discussion Point: *The research on the intrinsic factors that motivate a client's offending behaviors and attitudes is still emerging. Approved Providers are encouraged to explore the underlying sources of offending. This May include specific personality traits or disorders, certain types of cognitive schemas, and other considerations.*

4. Recognize and manage dynamic risk factors and adaptive skills to mitigate those risk factors.[11]

Potential Competencies: The following potential competencies may be required when clinically indicated for General criminality:[12]

- Recognize and manage current procriminal attitudes and behaviors.
- Identify, acknowledge, and manage use of mood-altering substances.
- Identify the history of current and former pro-criminal behaviors, thoughts, and associates *Self-Regulation and Self-Care*

Clients shall meet the following required competencies related to Self-Regulation and Self-Care:

5. Demonstrate and implement self-regulation skills to include but not limited to emotional regulation, stress management, communication skills, anger management, conflict resolution, problem solving, delayed gratification, parental and financial responsibility, etc.[13]

6. Demonstrate the ability to discuss past experiences and how any unresolved trauma may impact offending behavior as a way to adopt effective coping strategies.[14]

[10] Hilton, N. Z., Eke, A. W., Kim, S., & Ham, E. (2023). Coercive control in police reports of intimate partner violence: Conceptual definition and association with recidivism. *Psychology of Violence, 13*(4), 277–285; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573; Pornari, C. D., Dixon, L., & Humphreys, G. W. (2021). A preliminary investigation into a range of implicit and explicit offense supportive cognitions in perpetrators of physical intimate partner violence. *Journal of Interpersonal Violence, 36* (3-4), NP2079-2111; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs Responsivity-based family violence programs with male offenders. *Journal of Family Violence, 29*, 151-164. [11] Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence, 29*, 151-164.

[12] Okano, M., Langille, J., & Walsh, Z. (2016). Psychopathy, alcohol use, intimate partner violence: Evidence from two samples. *Law & Human Behavior, 40*(5), 517-523; Peters, J. R., Nunes, K. L., Ennis, L., Hilton, N. Z., Pham, A., & Jung, S. (2022). Latent class analysis of the heterogeneity of intimate partner violent men: Implications for research and practice. *Journal of Threat Assessment & Management*, Online Advance Publication, October 13, 2022; Robertson, E. L., Walker, T. M., & Frick, P. J. (2020). Intimate partner violence perpetration and psychopathy: A comprehensive review. *European Psychologist, 25*(2), 134-145.

[13] Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of the risk factors for intimate partner violence. *Partner Abuse, 3(3)*, 231-280; Farzan-Kashani, J., & Murphy, C. M. (2017). Anger problems predict long-term criminal recidivism in partner violent men. *Journal of Interpersonal Violence*, *32*(3), 3541-3555; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573; Rolle, L., Giardina, G., Caldarera, A., & Brustia, P. (2018). When intimate partner violence meets same sex couples: A review of same sex intimate partner violence. *Frontiers in Psychology, 9*(1506), 1-13; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence*, *29*, 151-164.

[14] Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of the risk factors for intimate partner violence. *Partner Abuse, 3(3)*, 231-280; Lee, K. A., Bright, C. L., & Betz, G. (2022). Adverse childhood experiences

Discussion Point: *The goal of this competency is to understand how past experiences have impacted the client and what ways they can deal with these issues differently in non-abusive ways.*

7. Develop and maintain prosocial activities and networks to include but not limited to completing

education, maintaining employment, obtaining stable housing, life skills, recreational and social activities, etc.[15]

Potential Competencies: The following potential competencies may be required when clinically indicated for the client to meet:

- Identify, acknowledge, and manage mental health needs and the development of supports.[16]
- Identify, acknowledge, and manage the need for crisis management and stabilization (i.e. suicidal or homicidal ideation, housing insecurity, client decompensation).[17]
- Identify, acknowledge, and manage their own reintegration into the community.[18]
- Identify, acknowledge, and manage boundaries.
- Identify and promote healthy sexual behavior, intimacy, and relationship skills.[19]
- Increase ability to recognize attachment issues.[20]

Survivor Impact and Community Safety

(ACEs), alcohol use in adulthood, and intimate partner violence (IPV) perpetration by black men: A systematic review. *Trauma, Violence, & Abuse, 23*(3), 372-389; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51.

[15] Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of the risk factors for intimate partner violence. *Partner Abuse, 3(3)*, 231-280; Gerstenberger, C., Stansfield, R., & Williams, K. R. (2019). Intimate partner violence in same-sex relationships. *Criminal Justice & Behavior, 46*(11), 1515-1527; Grace, F. X., McNary, S. B., & Murphy, C. M. (2022). Employment status and recidivism after relationship violence intervention. *Psychology of Violence*, 13(2), 127-135; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573; Spencer, C. M., & Stith, S. M. (2020). Risk factors for male perpetration and female victimization of intimate partner homicide: A meta-analysis. *Trauma, Violence, & Abuse, 21*(3) 527-540.

[16] Callan, A., Corbally, M., & McElvaney, R. (2021). A scoping review of intimate partner violence as it relates to the experiences of gay and bisexual men. *Trauma, Violence, & Abuse, 22*(2), 233-248; Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of the risk factors for intimate partner violence. *Partner Abuse, 3(3)*, 231-280; Dawson, M., & Piscitelli, A. (2021). Risk factors in domestic homicide: Identifying common clusters in the Canadian context. *Journal of Interpersonal Violence, 36*(1-2), 781-792; Morgan, et al. (2012). Treating offenders with mental illness: A research synthesis. *Law & Human Behavior, 36*(1), 37-50; Rolle, L., Giardina, G., Caldarera, A., & Brustia, P. (2018). When intimate partner violence meets same sex couples: A review of same sex intimate partner violence. *Frontiers in Psychology, 9*(1506), 1-13; Spencer, C. M., & Stith, S. M. (2020). Risk factors for male perpetration and female victimization of intimate partner homicide: A meta-analysis. *Trauma, Violence, & Abuse, 21*(3) 527-540; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51.

[17] Dawson, M., & Piscitelli, A. (2021). Risk factors in domestic homicide: Identifying common clusters in the Canadian context. *Journal of Interpersonal Violence, 36*(1-2), 781-792; Scott, K., Heslop, L., Kelly, T., & Wiggins, K. (2015). Intervening to prevent repeat offending among moderate-to-high risk domestic violence offenders: A second-responder program for men. *International Journal of Offender Therapy & Comparative Criminology, 59*(3), 273-294.

[18] Stansfiled, R., Semenza, D., Napolitano, L., Gatson, M., Coleman, M., & Diaz, M. (2022). The risk of family violence after incarceration: An integrative review. *Trauma, Violence, & Abuse, 23*(2), 476-489.

[19] Spencer, C. M., Toews, M. L., Anders, K. M., & Emanuels, S. K. (2021). Risk markers for physical teen dating violence perpetration: A meta-analysis. *Trauma, Violence, & Abuse, 22*(3), 619-631; Sparks, B., Wielinga, F., Jung, S., & Olver, M. E. (2020). Recidivism risk and criminogenic needs of individuals who perpetrated intimate partner sexual violence offenses. *Sexual Offending: Theory, Research, and Prevention, 15*(1), Article e3713.

[20] Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51.

Clients shall meet the following required competencies related to Survivor Impact and Community Safety:

8. Demonstrate insight about the impact of their domestic violence offense on all individuals and promote victim empathy when clinically indicated.[21]

Discussion Point: *Demonstration of this competency regarding the impact of a domestic violence offense can include, but is not limited to accountability letters, victim empathy panels, and surrogate offender and victim dialogue. Opportunities for any therapeutic work between the client and the*

identified victim or secondary victims may be done after the client has completed domestic violence offender treatment during aftercare.

9. Increase understanding of how intergenerational patterns of family, peer group, community, and culture can normalize domestic violence and foster attitudes and responses that condone and tolerate domestic violence.[22]

10. Develop and implement safety plans to address risk factors and potentially high-risk situations.[23] 11.

Cooperate with supervision requirements, court orders, and the terms and conditions.[24]

Potential Competencies: The following potential competencies may be required when clinically indicated for the client to:

- Increase understanding and demonstration of parental responsibility to enhance and ensure the wellbeing of the children.[25]

[21] Bichard, H., Byrne, C., Saville, C. W. N., & Coetzer, R. (2022). The neuropsychological outcomes of non fatal strangulation in domestic and sexual violence: A systematic review. *Neuropsychological Rehabilitation, 32*(6), 1164–1192; Godfrey, D. A., Kehoe, C. M., Bastardas-Albero, A., & Babcock, J. C. (2020). Empathy mediates the relations between working memory and perpetration of intimate partner violence and aggression. *Behavioral Sciences, 10*(3), 63; Hamel, J., Cannon, C. E. B., & Graham-Kevan, N. (2023, April 6). The consequences of psychological abuse and control in intimate partner relationships. *Traumatology*. Advance online publication; Holmes, M. R., Berg, K. A., Bender, A. E., Evans, K. E., O'Donnell, K., & Miller, E. K. (2022). Nearly 50 years of child exposure to intimate partner violence empirical research: Evidence mapping, overarching themes, and future directions. *Journal of Family Violence, 37*, 1207-1219; Lafontaine, M. F., Guzmán-González, M., Péloquin, K., & Levesque, C. (2018). I am not in your shoes: Low perspective taking mediating the relation among attachment insecurities and physical intimate partner violence in Chilean university students. *Journal of Interpersonal Violence, 33(*22), 3439–3458; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51.

[22] Copp, J. E., Giordano, P. C., Longmore, M. A., and Manning, W. D. (2019). The development of attitudes towards intimate partner violence: an examination of key correlates among a sample of young adults. *Journal of Interpersonal Violence, 34*, 1357–1387; Herrero, J., Rodríguez, F. J., and Torres, A. (2017). Acceptability of partner violence in 51 societies: The role of sexism and attitudes toward violence in social relationships. *Violence Against Women, 23*, 351–367; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573.

[23] Spencer, C. M., & Stith, S. M. (2020). Risk factors for male perpetration and female victimization of intimate partner homicide: A meta-analysis. *Trauma, Violence, & Abuse, 21*(3) 527-540; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence, 29*, 151-164.

[24] Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573.

[25] Hine, L., Meyer, S., McDermott, L., & Eggins, E. (2022). Intervention programme for fathers who use domestic and family violence: Results from an evaluation of Caring Dads. *Child & Family Social Work, 27*, 711-724; Labarre, M., Bourassa, C., Holden, G. W., Turcotte, P., & Letourneau, N. (2016). Intervening with fathers in the context of intimate partner violence: An analysis of ten programs and suggestions for a research agenda. *Journal of Child Custody, 13*(1), 1–29; Meyer, S. (2017). Motivating perpetrators of domestic and family violence to engage in behavior change: The role of fatherhood. *Child & Family Social Work, 23*(1), 97–104; Stover, C. S., Clough, B., Clough, M., DiVertro, S., Madigan, L., & Grasso, D. J. (2022). Evaluation of a statewide implementation of Fathers for Change: A fathering intervention for families impacted by partner violence. *Journal of Family Violence, 37*, 449-459.

Discussion Point: *If the offender has abused any pregnant partner, this may need to be addressed as an additional competency. In such cases, the client should demonstrate an understanding and insight that abuse during pregnancy may present a higher risk to the victim and unborn child.*

5.04 Length of Treatment

I. DURATION OF DOMESTIC VIOLENCE TREAMENT

THERE IS NO ASSIGNED DURATION FOR DOMESTIC VIOLENCE TREATMENT AS EACH CLIENT'S PROGRESS IS MADE ACCORDING TO THEIR OWN GAINS WITH THE CORE COMPETENCIES AND INDIVIDUALIZED TREATMENT GOALS. EACH CLIENT MAY PROGRESS DIFFERENTLY THAN OTHERS AND THUS MAY SPEND MORE OR LESS TIME IN TREATMENT. TREATMENT SPECIFICALLY ADDRESSES THE OCCURRENCE AND DYNAMICS OF DOMESTIC VIOLENCE AND UTILIZES DIFFERENTIAL STRATEGIES TO PROMOTE OFFENDER CHANGE. MUCH MORE IMPORTANCE IS GIVEN TO THE MEETING OF CORE COMPETENCIES AND INDIVIDUALIZED TREATMENT GOALS RATHER THAN THE PASSAGE OF A SPECIFIC AMOUNT OF TIME, SESSIONS, OR TPRS (SEE SECTION 5.07).

DISCUSSION POINT: THE DURATION OF TREATMENT IS NOT RESTRICTED TO THE TIMEFRAME THE CLIENT REMAINS UNDER SUPERVISION. IN THE EVENT SUPERVISION IS TERMINATED, CLIENTS ARE NO LONGER LEGALLY REQUIRED TO ATTEND DOMESTIC VIOLENCE TREATMENT AND CLIENTS HAVE THE OPTION TO CONTINUE OR DISCONTINUE RECEIVING SERVICES. IF A CLIENT CHOOSES TO DISCONTINUE RECEIVING SERVICES AFTER THEIR SUPERVISION IS TERMINATED AND THEY HAVE NOT MET THE TREATMENT COMPLETION DISCHARGE CRITERIA, THE CLIENT WILL RECEIVE AN UNSUCCESSFUL DISCHARGE IN ACCORDANCE WITH STANDARD 5.09.

II. **THERE ARE THREE PHASES OF DOMESTIC VIOLENCE OFFENDER TREATMENT:**

A. **PHASE 1: PREPARING READINESS, INTERNAL MOTIVATION, AND ENGAGEMENT (OPTIONAL)** B. **PHASE 2: DOMESTIC VIOLENCE OFFENDER TREATMENT**

C. ***PHASE 3: MAINTENANCE***

5.05 Preparing Readiness, Internal Motivation, and Engagement (Phase 1)

I. **APPROVED PROVIDERS MAY USE SHORT-TERM INTERVENTIONS THAT ARE DESIGNED TO SUPPORT THE CLIENT GETTING STARTED IN TREATMENT. PRIME IS OPTIONAL AND MAY BE UTILIZED BASED ON THE DISCRETION OF THE APPROVED PROVIDER. THESE SHORT-TERM INTERVENTIONS MAY:**

- **BEGIN PRIOR TO THE COMPLETION OF THE OFFENDER EVALUATION AS THESE CAN ALLOW FOR THE MTT TO EXPEDITE PLACEMENT OF THE CLIENT IN WRAPAROUND AND STABILIZATION SERVICES. DURING THESE INTERVENTIONS**
- **ALSO REQUIRE MODIFICATIONS TO BE REPORTED TO THE PRESIDING COURT OR PAROLE BOARD BASED ON EMERGING INFORMATION FROM THE OFFENDER EVALUATION.**

DISCUSSION POINT: CLIENTS WHO HAVE COMMITTED DOMESTIC VIOLENCE OFFENSES APPROACH TREATMENT WITH VARYING LEVELS OF AMBIVALENCE REGARDING ENGAGEMENT IN TREATMENT. APPROVED PROVIDERS SHOULD ADDRESS READINESS AREAS AND STRIVE TO DEVELOP A THERAPEUTIC ALLIANCE TO THE EXTENT POSSIBLE.

II. **APPROVED PROVIDERS IN CONJUNCTION WITH THE MTT MUST ESTABLISH SPECIFIC GOALS AND TASKS FOR CLIENTS WHO ARE NOT READY, ABLE AND WILLING TO BEGIN DOMESTIC VIOLENCE OFFENDER TREATMENT. THESE MEASURABLE GOALS SHALL BE OUTLINED IN A TREATMENT PLAN AND WILL ESTABLISH WHETHER CLIENTS HAVE REACHED GOALS TO CONTINUE INTO DOMESTIC VIOLENCE OFFENDER TREATMENT AT THE END OF THE FIRST TREATMENT PLAN REVIEW.**

III. **APPROVED PROVIDERS CAN TRANSITION A CLIENT INTO THE SECOND PHASE OF TREATMENT ONCE THE CLIENT HAS MET THE SPECIFIED PRIME GOALS. THE APPROVED PROVIDER, IN CONSULTATION WITH THE MTT, MAY MOVE A CLIENT BACK TO PHASE 1 AT ANYTIME BASED ON CLINCIAL INDICATORS OF CLIENT PARTICIPATION IN PHASE 2.**

A. PREPATORY TREATMENT

APPROVED PROVIDERS MAY USE SHORT-TERM INTERVENTIONS THAT ARE FOCUSED ON INITIAL CLIENT READINESS FOR TREATMENT, ADDRESSING POTENTIAL BARRIERS TO TREATMENT, AND OFFERING PSYCHOEDUCATIONAL CONTENT.

- **PROTECTION ORDER COMPLIANCE**

- **CYCLE OF VIOLENCE**
- **STAGES OF CHANGE**
- **ACCOUNTABILITY**
- **TREATMENT OVERVIEW**

B. ACCOUNTABILITY INTERVENTIONS

When a CLIENT is in severe denial, the MTT shall consider ACCOUNTABILITY INTERVENTIONS. IT IS ESPECIALLY IMPORTANT TO DOCUMENT THE CLIENT'S RESPONSIBILITY FOR THEIR DOMESTIC VIOLENCE BEHAVIOR. THE SHORT-TERM INTERVENTION MAY INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING TREATMENT GOALS:

- **ADDRESSING VICTIM IMPACT**
- **DEVELOPING A THERAPEUTIC RELATIONSHIP**
- **DECREASING STIGMA AND SHAME**
- **FOCUSING ON DISTORTED THOUGHT PATTERNS RELATED TO THE OFFENSE**
- **SUPPORTING CLIENT MOTIVATION**
- **USE OF CLIENT SUPPORT SYSTEMS**
- **ADDRESSING CLIENT TRAUMA HISTORY**
- **PROVIDING PSYCHOEDUCATION**
- **UTILIZE CULTURALLY RELEVANT INTERVENTIONS**

Discussion Point: Placing a CLIENT with severe denial in group with OTHER CLIENTS who are not exhibiting severe denial may not be appropriate for the CLIENT or the group.

C. OFFENDER EVALUATION

THESE SHORT-TERM INTERVENTIONS MAY BEGIN PRIOR TO THE COMPLETION OF THE OFFENDER EVALUATION AS THESE CAN ALLOW FOR THE MTT TO EXPEDITE PLACEMENT OF THE CLIENT IN WRAPAROUND AND STABILIZATION SERVICES. DURING THESE INTERVENTIONS, IT IS ALSO POSSIBLE FOR ANY MODIFICATIONS NEEDED TO BE REPORTED TO THE PRESIDING COURT OR PAROLE BOARD BASED ON EMERGING INFORMATION FROM THE OFFENDER EVALUATION.

5.06 Domestic Violence Offender Treatment (Phase 2)

I. Program Design

Approved Providers shall design programs **THAT ARE RESEARCH-INFORMED THAT BEST ADDRESS DYNAMIC RISK AND INDIVIDUALIZE TREATMENT IN WAYS THAT ARE TRAUMA INFORMED AND CULTURALLY RESPONSIVE. THE PROGRAM DESIGN SHOULD USE AN ARRAY OR MIXTURE OF THEORETICAL APPROACHES THAT BRIDGE PSYCHODYNAMIC, COGNITIVE BEHAVIORAL, NEUROLOGICAL, AND OTHER STRATEGIES**. Adjunctive approaches may be used, but never substituted for the primary approach. **APPROVED PROVIDERS SHALL INCORPORATE STRENGTH-BASED INTERVENTIONS WITH THE GOAL OF AIDING THE CLIENT IN DESISTING FROM DOMESTIC VIOLENCE BEHAVIORS. SUCH INTERVENTIONS WILL INCLUDE APPROACH-ORIENTED GOALS THAT WILL ENHANCE INHERENT AND/OR DEVELOPED PRO SOCIAL STRENGTHS.**

STAFF NOTE HERE THAT THE RECENTLY APPROVED AND PUBLISHED STANDARDS FOR GROUP, INDIVIDUAL, AND TELETHERAPY MODALITIES CURRENTLY LISTED IN 5.04 WILL BE PLACED HERE.

V. Couples or Family Counseling

WHILE THE CLIENT IS IN DOMESTIC VIOLENCE OFFENDER TREATMENT, CLIENTS ARE PROHIBITED FROM PARTICIPATING IN ANY FORM OF COUPLES COUNSELING, FAMILY COUNSELING, OR VICTIM-OFFENDER DIALOGUE.

DISCUSSION POINT: *Couple's counseling is not a component of domestic violence treatment. The offender is the client in offender treatment, not the couple, and not the relationship. Because of the potential therapeutic challenges of concurrent treatment along with dangers and risk to victim safety, this standard further clarifies that offenders will not participate in marriage or couple's counseling of any kind with anyone with the victim outside of offender treatment. Therefore, couple's counseling is not permitted during domestic violence offender treatment. The offender is prohibited from participating in any couples counseling while in offender treatment. This includes any joint counseling that involves the offender and the victim.*

VI. Responsivity Considerations

Effective service delivery of treatment and supervision requires individualization that matches the offender's culture, learning style, and abilities, among other factors. Responsivity factors are those factors that may influence an individual's responsiveness to efforts that assist in changing an offender's attitudes, thoughts, and behaviors.

RESPONSIVITY FACTORS (TO INCLUDE BUT NOT LIMITED TO MOTIVATION FOR TREATMENT, CULTURE, LEARNING STYLE, LEVEL OF FUNCTIONING, DEVELOPMENTAL MATURITY, AND LANGUAGE SKILLS) SHALL BE IDENTIFIED AND INCORPORATED WHEN DETERMINING THE COURSE OF TREATMENT IN ACCORDANCE WITH APPENDIX _.

THE PROVIDER SHALL EMPLOY TREATMENT METHODS THAT ARE RESPONSIVE TO THE ASSESSED NEEDS OF THE CLIENT AND EMPHASIZE THE PHYSICAL AND PSYCHOLOGICAL SAFETY OF VICTIMS AND POTENTIAL VICTIMS. TREATMENT SHALL BE RESPONSIVE TO THE CLIENT'S LEVEL OF INTELLECTUAL FUNCTIONING, LEARNING STYLE, PERSONALITY CHARACTERISTICS, CULTURE, MENTAL AND PHYSICAL DISABILITIES, MOTIVATION LEVEL, AND LEVEL OF RESPONSIBILITY.

5.07 Levels of Treatment

I. **APPROVED PROVIDERS SHALL INDIVIDUALIZE A CLIENT'S TREATMENT TO ALIGN WITH THE ASSESSED LEVEL OF RISK BASED ON INDIVIDUAL FACTORS OF THE CLIENT. THERE ARE FIVE TREATMENT INTENSITY LEVELS AS SHOWN IN TABLE _. IT IS IMPORTANT FOR TREATMENT INTENSITY TO BE CONGRUENT WITH THE CLIENT'S RISK AND NEED TO INCREASE THE LIKELIHOOD OF A POSITIVE TREATMENT OUTCOME.**

TABLE _. TREATMENT INSENSITY LEVELS AND TREATMENT PLAN REVIEWS

LEVEL	MINIMUM NUMBER OF TREATMENT PLAN REVIEWS	MINIMUM LENGTH OF TREATMENT
1 VERY LOW INTENSITY	1 OR MORE	2 TO 4 MONTHS OR MORE
2 LOW INTENSITY	2 OR MORE	4 TO 8 MONTHS OR MORE

3 MODERATE INTENSITY	3 **OR MORE**	**6 TO 12 MONTHS OR MORE**
4 MODERATE-HIGH INTENSITY	4 **OR MORE**	**8 TO 16 MONTHS OR MORE**
5 HIGH INTENSITY	5 **OR MORE**	**10 TO 20 MONTHS OR MORE**

DISCUSSION POINT: APPROVED PROVIDERS HAVE THE DISCRETION TO ADJUST THE TIMING OF TREATMENT PLAN REVIEWS WITHIN ESTABLISHED TIMEFRAMES, EITHER EARLIER OR LATER, BASED ON CLIENT MOTIVATION, PROGRESS, COMPLIANCE, AND EFFORT WHILE IN TREATMENT.

II. **THE ASSIGNMENT OF A TREATMENT LEVEL SHALL BE DETERMINED BY THE APPROVED PROVIDER WITHIN THE FIRST 30 DAYS OF TREATMENT USING THE COMBINED STATIC AND DYNAMIC SCORE OF THE COLORADO ASSESSMENT SCALE FOR COERCION AND ABUSE DESISTANCE (CASCADE) OBTAINED THROUGH THE OFFENDER EVALUATION.**

A. IF THE OFFENDER EVALUATION IS INCOMPLETE, THE MTT SHALL TAKE THIS INTO ACCOUNT FOR THE DESIGNATED TREATMENT INTENSITY LEVEL. ONCE THE EVALUATION IS COMPLETE, THE APPROVED PROVIDER SHALL DETERMINE THE APPROPRIATE TREATMENT LEVEL INTENSITY.

DISCUSSION POINT: A CLIENT MAY BE TEMPORARILY PLACED IN PRIME TO ALLOW TIME TO GATHER INFORMATION RELATED TO RISK FACTORS AND SAFETY CONSIDERATIONS TO FINALIZE THE EVALUATION.

III. **THE PROVIDER SHALL COLLABORATE WITH THE MTT REGARDING THE NEED TO REFER A CLIENT TO A DIFFERENT PROGRAM TO APPROPRIATELY TREATMENT MATCH TO THE CLIENT'S NEEDS.**

IV. **THE CLIENT SHALL:**

A. Participate in domestic violence offender treatment in an effort to address and reduce risk factors through the Core Treatment Competencies. Outside of the Core Treatment Competencies, some **CLIENTS** will have additional treatment goals based on dynamic risk factors or responsivity considerations.

B. Participate in the minimum number of required Treatment Plan Reviews at identified intervals based on **THE FINDINGS FROM THE OFFENDER EVALUATION, THE TREATMENT PLAN, AND LEVEL OF COMPOSITE RISK IDENTIFIED BY THE CASCADE.**

V. LOW RISK CLIENTS SHALL BE IDENTIFIED AND SEPARATED FROM MODERATE AND HIGH RISK CLIENTS IN TREATMENT GROUPS. APPROVED PROVIDERS SHALL NOT ASSIGN CLIENTS TO GROUPS COMPRISED OF INDIVIDUALS PRESENTING AS MODERATE AND HIGH-RISK CLIENTS.

DISCUSSION POINT: DIFFERENTIATING CLIENT RISK IS A CRITICAL PART OF THE THERAPEUTIC PROCESS IN ORDER TO LIMIT THE DEGREE TO WHICH LOW RISK CLIENTS ARE EXPOSED TO HIGH RISK CLIENTS, BECAUSE SUCH EXPOSURE MAY

INCREASE A LOW RISK CLIENT'S RISK TO RE-OFFEND. CLIENTS *in all levels of treatment may be placed together for some educational, non-therapeutic or non processing sessions.*

VI. **RISK ASSESSMENT IS AN ONGOING PROCESS THROUGHOUT THE CLIENT'S TREATMENT. WHILE CLIENTS REMAIN IN THE SAME LEVEL THROUGHOUT TREATMENT, PROVIDERS HAVE DISCRETION TO MAKE ADJUSTMENTS (E.G. TRANSITIONING A CLIENT TO A DIFFERENT GROUP) TO THE TREATMENT PLAN BASED ON CLINICAL INDICATORS. THIS PROCESS SHOULD BE FACILITATED CAREFULLY BASED ON NEW INFORMATION SUCH AS CHANGES IN RISK FACTORS, MITIGATION OF RISK FACTORS, OR OTHER EMERGING CLINICAL ISSUES. WHEN LIMITED RESOURCES PREVENT THE PROVIDER FROM ESTABLISHING A LOW-RISK TREATMENT GROUP, IT IS IMPORTANT TO IMPLEMENT STRATEGIES AND INTERVENTIONS THAT ARE BASED ON CLIENT RISK LEVELS SUCH AS THE USE OF INDIVIDUAL SESSIONS.**

DISCUSSION POINT: ALTERNATIVE MODALITIES CAN BE USED WHEN GROUP THERAPY IS NOT SUITABLE OR AVAILABLE. THIS MIGHT BE DUE TO A CLIENT'S RISK LEVEL (E.G., LOW-RISK), SPECIFIC NEEDS (E.G., CLIENT WHO IDENTIFIES AS TRANS), LANGUAGE ISSUES, OR IF THEY BELONG TO A UNIQUE GROUP (E.G, CLIENT WITH A DEVELOPMENTAL DISABILITY). FOR MORE INFORMATION, PLEASE SEE STANDARD 5.06.

5.08 SECOND CONTACT RECOMMENDATIONS RELATED TO CORE TREATMENT COMPETENCIES

I. THE TERM "SECOND CONTACT" REFERS TO ADJUNCT TREATMENTS AND INTERVENTIONS THAT ARE IN ADDITION TO WEEKLY DOMESTIC VIOLENCE OFFENDER SESSIONS AND DESIGNED TO ADDRESS ANY (1) CO-OCCURRING RISK-RELATED NEEDS WITH THE CLIENT OR (2) ANY RESPONSIVITY FACTORS AS INDICATED IN THE TREATMENT PLAN. IN ACCORDANCE WITH THE SECOND CONTACT FREQUENCY TABLE _, THE FREQUENCY AND INTENSITY OF SECOND CONTACTS PROGRESSIVELY INCREASE WITH THE PRESENCE OF DYNAMIC RISK FACTORS. DYNAMIC RISK INCLUDES A WIDE RANGE OF FACTORS INCLUDING CO-OCCURING CONDITIONS, CRIMINOGENIC NEEDS, OR OTHER RISK-RELATED INDICATORS ABOUT THE CLIENT THAT ARE DETERMINED BY THE CASCADE. SECOND CONTACTS MAY ALSO BE USED TO ADDRESS CLIENT SPECIFIC RESPONSIVITY FACTORS.

DISCUSSION POINT: SECOND CONTACTS PLAY A VITAL ROLE BECAUSE THEY INCREASE THE AMOUNT OF TREATMENT IN ORDER TO INDIVIDUALIZE SUPPORT TO CLIENT'S CHANGE PROCESS. THIS TARGETED APPROACH ENHANCES RISK-REDUCTION AND THE OVERALL EFFECTIVENESS OF TREATMENT BY USING A COMPREHENSIVE RESPONSE TO A CLIENT'S UNIQUE RISK PROFILE, GOING BEYOND GENERAL GROUP WORK. BY PROACTIVELY ADDRESSING CO-OCCURRING CONDITIONS, SUBSTANCE ABUSE, MENTAL HEALTH ISSUES, OR PRO-CRIMINAL ATTITUDES, SECOND CONTACTS ALLOW FOR THE SYSTEMATIC INTEGRATION OF SPECIFIC TREATMENT COMPETENCIES. THE MULTIDISCIPLINARY TREATMENT TEAM (MTT) MUST CAREFULLY CONSIDER THE USE OF THESE SECOND CONTACTS TO DETERMINE SPECIFIC NEEDS, ENSURING TREATMENT INTENSITY AND FOCUS ALIGN WITH THE EVOLVING DYNAMIC RISK FACTORS AND RESPONSIVITY CONSIDERATIONS.

II. RISK ASSESSMENT IS AN ONGOING PROCESS THROUGHOUT THE CLIENT'S TREATMENT. AS A CLIENT'S RISK, NEEDS, OR RESPONSIVITY CHANGE, THE PROVIDER SHALL MAKE ADJUSTMENTS TO THE TYPE, FREQUENCY, AND INTENSITY OF SECOND CONTACTS BASED ON CLINICAL INDICATORS. CLIENT RISK IS DYNAMIC AND MAY INCREASE OR DECREASE DURING TREATMENT RESULTING IN THE NEED FOR MODIFICATIONS TO THE CLIENT'S TREATMENT PLAN.

III. **THE CLIENT SHALL PARTICIPATE IN THE REQUIRED SECOND CONTACTS THROUGHOUT THE DURATION OF DOMESTIC VIOLENCE OFFENDER TREATMENT BASED ON CLINICAL INDICATORS IN ACCORDANCE WITH THE SECOND CONTACT SCHEDULE IN TABLE _.**

DISCUSSION POINT: CLIENTS NEED TO BE AWARE THAT THEY MAY BE REQUIRED TO PARTICIPATE IN MORE CONTACTS THAN INDICATED IN THE TABLE TO MORE HOLISTICALLY ADDRESS TREATMENT NEEDS FOR THE CLIENT.

IV. **APPROVED PROVIDERS SHALL:**

- **DETERMINE THE MOST PROMINENT TREATMENT NEED AS WELL AS THE MOST APPROPRIATE INTERVENTION FOR PURPOSES OF MEETING THE REQUIRED SECOND CONTACT SCHEDULE IN TABLE _.**

TABLE _. SECOND CONTACT FREQUENCY

LEVEL	**MINIMUM RANGE OF ADDITIONAL CONTACTS:**
1 **VERY LOW INTENSITY**	UNSPECIFIED AND DETERMINED CASE-BY-CASE
2 LOW INTENSITY	0 - 1 MONTHLY CONTACTS
3 MODERATE INTENSITY	1 - 2 MONTHLY CONTACT
4 MODERATE-HIGH INTENSITY	2 - 4 MONTHLY CONTACTS
5 HIGH INTENSITY	1 OR MORE WEEKLY CONTACT

- **NOTIFY THE MTT OF THE SECOND CONTACT, CONSIDER ANY INFORMATION REGARDING THE SECOND CONTACT DETERMINATION, AND ANY SUBSEQUENT SECOND CONTACT MODIFICATIONS.**

- Modify **SECOND CONTACT** requirements in accordance with **the SECOND CONTACT FREQUENCY** Table, **EITHER BY ADDING SPECIFIC GOALS** when clinically indicated OR **REMOVING SPECIFIC GOALS WHEN SUFFICIENTLY MET BY THE CLIENT**.

- **BE RESPONSIBLE FOR MONITORING AND MAINTAINING COMMUNICATION WITH THE SECOND CONTACT PROFESSIONAL, UNLESS THAT RESPONSIBILITY HAS BEEN REFERRED TO AND AGREED UPON BY THE SUPERVISING AGENT.**

- **DOCUMENT EFFORTS TO INCLUDE THE SECOND CONTACT PROFESSIONAL AS PART OF THE MTT TO FACILITATE COMMUNICATION AND MONITORING.**

- **ORIENT THE CLIENT AT THE START OF TREATMENT TO THE PURPOSE AND NEED FOR A SECOND CONTACT FOR THE DURATION OF TREATMENT.**

- **DOCUMENT THE DESIGNATED SECOND CONTACT AND ANY MODIFICATIONS TO SECOND CONTACTS IN THE CLIENT'S TREATMENT PLAN.**

V. **IF A CLIENT IS INVOLVED IN ADDITIONAL INTERVENTION OR TREATMENT SERVICES, THE APPROVED PROVIDER SHALL EVALUATE WHETHER THOSE SECONDARY SERVICES ADEQUATELY ADDRESS THE CLIENT'S PREDOMINANT TREATMENT NEED AS THEIR DESIGNATED SECOND CONTACT.**

VI. **IF ANY KNOWN INTERVENTIONS OR TREATMENTS INTERFERE WITH THE CLIENT'S EFFECTIVE PARTICIPATION IN DOMESTIC VIOLENCE OFFENDER TREATMENT, THE APPROVED PROVIDER SHALL NOTIFY THE MTT AND THE CLIENT OF THEIR CONCERNS. IF ANY CONCERNS IDENTIFIED CANNOT BE RESOLVED, THE APPROVED PROVIDER MAY DISCHARGE THE CLIENT IF THEY DETERMINE ANY INTERVENTIONS OR TREATMENTS ARE CONTRA-INDICATED.**

VII. **INTERVENTIONS OR TREATMENTS ARE INELIGIBLE AS A SECOND CONTACT IF: ● THE SECOND CONTACT IS DETERMINED TO BE INAPPROPRIATE BY THE APPROVED PROVIDER PER STANDARD 5.02(II);**
- **THE SECOND CONTACT UNDERMINES THE GOALS OF DOMESTIC VIOLENCE OFFENDER TREATMENT;**
- **THE SECOND CONTACT PRESENTS RISKS OR SAFETY CONCERNS REGARDING THE VICTIM AND/OR THE CLIENT;**

VIII. **SOME POTENTIAL SECOND CONTACT RECOMMENDATIONS MAY INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:**
- **INDIVIDUAL PSYCHOTHERAPY**
- **MENTAL HEALTH TREATMENT**
- **SUBSTANCE USE DISORDER THERAPY, RELAPSE PREVENTION**
- **MORAL RECONATION THERAPY (MRT)**
- **DOMESTIC VIOLENCE ACCEPTANCE AND COMMITMENT THERAPY (ACT) ● DENIAL OR RESISTANCE FOCUSED INTERVENTIONS**
- **EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR), DIALECTICAL BEHAVIOR THERAPY (DBT), TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)**
- **PARENTING PROGRAMMING DESIGNED FOR DOMESTIC VIOLENCE**

5.09 Treatment Plan Reviews

The purpose of the Treatment Plan Review process is to assess and update the Treatment Plan based on indicators of risk, client progress toward goals, and safety planning.

I. The timeframe for a Treatment Plan Review begins the date the client **ATTENDS THEIR FIRST DOMESTIC VIOLENCE TREATMENT SESSION.**

II. The Approved Provider shall perform a Treatment Plan Review (TPR) **EVERY 2 TO 4 MONTHS** and assess the offender's progress toward meeting treatment goals. During each TPR, the Approved Provider shall:

A. Orient the client as to the purpose of a Treatment Plan Review

B. **REASSESS CLIENT RISK USING THE CASCADE**

C. **ADJUST AND INCORPORATE THE TREATMENT PLAN BASED ON THE RESULTS OF THE CASCADE AND OTHER CLINICAL INDICATORS OF PROGRESS AND A REVIEW OF THE CLIENT'S UNDERSTANDING AND APPLICATION OF COMPETENCIES.**

D. **PROVIDE FEEDBACK AND GUIDANCE TO THE CLIENT REGARDING THEIR PROGRESS.** E. **UPDATE THE MTT REGARDING TREATMENT PLAN MODIFICATIONS AND THE REVIEW WITH THE CLIENT.**

F. Recommend any additional TPRs **BEYOND THE MINIMUM REQUIRED** if the client is not ready for discharge.

III. Clients **SHALL:**

A. Sign the Treatment Plan to acknowledge the review **OCCURRED AND AGREE TO ANY MODIFICATIONS**.

B. **ACKNOWLEDGE THAT THEY CANNOT BE** eligible for **A TREATMENT COMPLETION** discharge **UNTIL THEY HAVE MET THE MINIMUM NUMBER OF TREATMENT PLAN REVIEW PERIODS ASSOCIATED WITH THEIR TREATMENT INTENSITY LEVEL.**

Discussion Point: CLIENTS SHOULD PLAY AN ACTIVE AND CRUCIAL ROLE IN THEIR TREATMENT JOURNEY. WHILE APPROVED PROVIDERS ARE RESPONSIBLE FOR FACILITATING TREATMENT AND CONDUCTING REGULAR TREATMENT PLAN REVIEWS, CLIENTS ARE ENCOURAGED TO SELF ADVOCATE, ASK QUESTIONS ABOUT THEIR PROGRESS AND TREATMENT PLAN REVIEWS, AND ACTIVELY PARTICIPATE IN SETTING THEIR OWN GOALS. TAKING OWNERSHIP OF THEIR CHANGE PROCESS AND DEMONSTRATING INTRINSIC MOTIVATION WILL SIGNIFICANTLY IMPACT THEIR SUCCESS IN ACHIEVING LASTING NON-ABUSIVE BEHAVIORS.

5.10 Maintenance Phase of Treatment (Phase 3)

THE MAINTENANCE PHASE IS A CRITICAL STAGE IN THE TREATMENT PROCESS, WITH THE PRIMARY GOAL TO CONSOLIDATE THERAPEUTIC GAINS, SUSTAIN RECOVERY, AND PROMOTE DESISTANCE FROM ABUSE OVER THE LONG TERM. THIS THIRD PHASE OF TREATMENT INVOLVES REINFORCING NEWLY ACQUIRED SKILLS, CONTINUOUS MONITORING FOR SIGNS OF REGRESSION, AND PROMOTING THE GENERALIZATION OF THERAPEUTIC PROGRESS INTO THE CLIENT'S DAILY LIFE. THE ULTIMATE AIM IS TO EMPOWER CLIENT SELF-EFFICACY IN BECOMING SELF-SUFFICIENT AND CAPABLE OF MAINTAINING NONVIOLENCE AND ESTABLISHING A LIFESTYLE MARKED BY STABLE, MEANINGFUL, AND PRO-SOCIAL BEHAVIORS.

I. **THE MAINTENANCE PHASE OF TREATMENT GIVES THE CLIENT THE ABILITY TO DEMONSTRATE THE TREATMENT GAINS AND TOOLS LEARNED WITHIN DOMESTIC VIOLENCE TREATMENT. A CLIENT MAY MOVE INTO THE MAINTENANCE PHASE OF TREATMENT UPON:**

- **A. COMPLETING ALL THE TREATMENT OBJECTIVES OUTLINED IN THE INDIVIDUALIZED TREATMENT PLAN;**
- **B. SUSTAINING COMPLIANCE WITH THE PROGRAM EXPECTATIONS OF TREATMENT AND SUPERVISION; AND**
- **C. APPEARING READY FOR A MORE AUTONOMOUS PHASE OF TREATMENT AS PART OF THEIR LAST TREATMENT PLAN REVIEW. MOVEMENT INTO THE MAINTENANCE PHASE OF TREATMENT SHOULD BE THE TREATMENT PROVIDER'S DECISION BASED ON THE CLIENT'S RISK AND NEEDS.**

II. **DURING THIS PHASE OF TREATMENT, THE CLIENT SHALL FINALIZE THE FOLLOWING: A. PERSONAL CHANGE PLAN - A CLIENT'S PERSONAL CHANGE PLAN INCLUDES A PLAN FOR PREVENTING ABUSIVE behaviors, identifying triggers, identifying cycles of abusive thoughts and behaviors, as well as a plan for preventing or interrupting the triggers and cycles. This plan is to be designed and implemented during treatment and utilized after discharge as well.**

B. AFTERCARE PLAN - A CLIENT'S written plan for utilizing concepts learned in treatment. This plan shall include ways to address individual risk factors, criminogenic needs and continued pro-social support systems in order to maintain non-abusive long-term change.

PLEASE NOTE THERE ARE NO CHANGES TO THE STANDARDS RELATED TO OFFENDER DISCHARGE. THE CURRENT SECTION 5.08 WILL BE PLACED HERE WITH THE NUMERATION OF 5.11.