

ADDRESSING FAMILY VIOLENCE IN CONNECTICUT: STRATEGIES, TACTICS AND POLICIES

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EXECUTIVE SUMMARY

At the request of the Connecticut General Assembly's (CGA) Public Health Committee, the Connecticut Academy of Science and Engineering (CASE) conducted this study to identify strategies, tactics and policies that can be employed in Connecticut to reduce the incidence of family violence perpetrated by adults and adolescents by targeting the common causes of violence.

There is concern among the general public and the state's leadership regarding family violence/intimate partner violence (IPV) perpetrated by adults and adolescents in Connecticut, as well as across the United States. Efforts to reduce family violence are numerous, but many standard interventions to accomplish this goal achieve minimal benefits. Additionally, family violence, and in particular, the impact of such violence directed at women, children and elders, is of particular concern. The issues and challenges that need to be addressed to identify effective research-based solutions to successfully reduce violence are known to be complex.

This study includes:

- A review of the literature on family violence prevention and treatment, along with follow-up consultation with local and national experts, including the Centers for Disease Control; economic, social, psychiatric, and biologic risk factors that increase the risk of family violence; and consequences of domestic violence on children, including its impact on adjustment in the school setting.
- Mining of available existing databases to identify the characteristics of perpetrators and victims of family violence, and the risk factors associated with recidivism and extreme forms of family violence (e.g., homicide).
- A summary of Connecticut's current state legal practices and service approaches that deal with family violence, including how the court system handles youthful and first-time adult offenders for intra-familial violence offenses. Also, Connecticut's practices and approaches are compared to other relevant state and national model programs and initiatives.
- Recommendations based on the research that identify prevention strategies for the state's consideration for the purpose of reducing family violence in Connecticut. A combination of variables was taken into account in formulating the study recommendations including the literature review, mining of Connecticut data sets, findings from a focus group session, guidance from expert consultants, formal presentations of research trends, committee discussion and integration of the findings from the research.

BRIEF STATEMENT OF PRIMARY CONCLUSION

Family violence continues to be an escalating and pervasive public health problem in many societies across the world. In Connecticut there were approximately 20,000 family violence arrests in 2012. A high percentage of these arrests included minor physical injuries to women, the presence or involvement of children in the family violence incident, and noted involvement of a weapon and/or substance use.

The literature also indicates that children who witness abuse in their home are at risk of becoming a victim or an offender into their adult years with co-occurring behavioral health disorders and medical problems. Family violence is a multi-generational problem that needs serious attention. Family violence is no different than other contagious diseases. Family violence tends to be passed on as a negative contagion within the family from one generation to the next and it is pervasive. The side effects include numerous behavioral health problems including drug use, depressive disorders, anxiety disorders and illegal behavior, among others. Each of these negative sequelae are also costly to the family and society – with family violence serving as a breeding ground for mental illness and addiction.

In the United States, the estimated economic cost of IPV (e.g., physical assault, sexual assault and stalking) exceeds \$5.8 billion each year. In fact, it is estimated that \$4.1 billion of the cost of the consequences of IPV is directly related to medical and mental health care services, and nearly \$.9 billion is due to lost work productivity of victims and offenders.

Current research indicates that the “one size fits all” treatment as usual approach (e.g., large group treatment settings that fail to treat co-occurring behavioral health problems such as mental illness or addiction for male offenders) has been costly and ineffective. Moreover, the research community has called for IPV intervention reform and highlighted the need to utilize treatment approaches grounded in science and theory and/or empirically supported treatments rather than adherence to unsubstantiated etiological models or old standards of treatment. Although the direct cost of tailoring treatments to make them client-centered to address the complex treatment needs of the offender and/or family will be more expensive than the traditional large treatment group settings, treatment outcomes will improve and lead to additional cost savings. The goal is to prevent family violence from being passed from one generation to the next, with a focus on creating a healthy home to reduce violence.

RECOMMENDATIONS

Recent research has challenged the dogmatic paradigm called the “patriarchal paradigm” that has guided domestic violence research, intervention and policy for the past three decades (Babcock and Ross 2009; Hamel 2007; Dutton; 2006). Recently, the Veterans Health Administration of the US Department of Veterans Affairs published policies and procedures that prohibit the use of Duluth Models as an intervention for veterans (Veterans Health Administration 2013). The VA’s federal guidelines noted that veterans have multiple and complicated treatment needs that require interventions grounded in science (e.g., trauma, addiction, psychiatric disorders, traumatic head injuries and/or medical illness, pain).

In Connecticut, some family violence guidelines prohibit mental health and addiction treatment as an acceptable stand-alone intervention for family violence, as the offender should be held

accountable and not allowed to use addiction or mental illness as an excuse. Old paradigms that use this rationalization a standard or guideline are unethical and potentially contribute to the risk of violence in the home, since these behavioral health problems will remain untreated. Moreover, failing to address other mental health, addiction, affective or behavioral targets may hinder progress in the field of IPV treatment and further reinforce stagnation in the IPV field.

The Literature Review section of this report provides a summary of multiple variables and risk factors in the etiologies of IPV. For example, there is a high co-occurrence of addiction (Easton et al. 2007; Leonard 2005), trauma (Crane et al. 2013a; Crane et al. 2013b) and personality characteristics (Dutton 2006) linked to IPV (Crane et al. 2013a; Crane et al. 2013b). Moreover, Dutton (2006) states that personality disorders are six times more relevant predictors of male-female offending than other typologies. Research underscores the importance of typologies and psychiatric diagnoses linked to IPV in addition to gender, power and control theory (Marlowe 2007; McMurrin and Gilchrist 2008; Dutton 2006; Holtzworth-Munroe et al. 2004). It should be noted that the Duluth Model associated with gender, power and control theory may help a subgroup of offenders, but research results available on this should be interpreted with caution due to the lack of well-controlled randomized trials.

Research on level of risk, the linkage to type of treatment, legal consequences and type and frequency of judicial involvement play critical roles in decreasing re-offending and recidivism. Research suggests that an individual with family-only typology is a lower-risk offender with a better treatment prognosis – when treatment is linked to evidence-based behavioral therapy approaches and judicial oversight – compared to an offender with personality disorders (e.g., general violent-antisocial typology, antisocial personality disorder, borderline-dysphoric, narcissism, sadistic) who is a high-risk offender needing stringent judicial oversight (Marlowe 2012).

Researchers stress the importance of utilizing a “risk-needs approach” when assessing how to best treat men who are arrested for domestic violence (McMurrin and Gilchrist 2008). Eckhardt highlights the need to understand the link between substance use, extensive anger disturbances and anger expression characteristics (Eckhardt et al. 2008) in the linkage to effective treatments. McMurrin and Gilchrist (2008) note the inherent problems in applying a Duluth Model approach when anger and drinking might be better addressed by interventions designed to treat anger and drinking as opposed to addressing solely “control issues” via the Duluth Model. Moreover, as previously stated, failing to address other mental health, addiction, affective or behavioral targets may hinder progress in the field of IPV treatment, further reinforcing stagnation in the IPV field while rates of IPV remain unchanged or escalate.

Research reviews have indicated that the “treatment as usual” approach (e.g., a one size fits all approach/Duluth derivatives) for male offenders has been costly and ineffective (e.g., Babcock, Green, & Robie 2004; Babcock & LaTaillade 2000). The research community has called for IPV intervention reform and highlighted the need to utilize additional treatment approaches grounded in science and theory and/or empirically supported treatments rather than adherence to unsubstantiated etiological models or old standards of treatment (e.g., Eckhardt, Murphy, Black, & Suhr 2006).

Integrative Cognitive Behavioral Therapy (CBT) and trauma-informed approaches such as the integration of care models for veterans have shown the most promise in reducing co-occurring

behavioral health disorders and IPV (Veterans Health Administration 2013). Other directions include assessing CBT with and without various pharmacotherapies, as adjunctive medication may further improve treatment outcomes with this population and lead to prolonged abstinence from substance use and violence.

Clinical Recommendations

TRAINING, EDUCATION, AND SUPERVISION

- Require license/qualifications/training and supervision for clinicians providing care to offenders. Moreover, ongoing training and supervision should be available to clinicians who treat offenders.
- Train frontline clinicians (i.e., social workers, clinical psychologists and psychiatrists), judges, attorneys, EMTs, ER medical staff regarding offender treatment needs with a focus on coordination of care and ongoing communication of care/judicial involvement.
- Consider Bridgeport's specialized domestic violence docket and model for diversion as a training guide for other Connecticut courts.

EVALUATION OF FAMILY VIOLENCE TREATMENT NEEDS AND RISK

Assess treatment needs for the family when children are involved and integrate parenting approaches and treatment needs for the child (e.g., integration of care models and Multi-systemic Therapy [MST] approach) with the entire family if clinically indicated. Examples when this is clinically contra-indicated occur when protective orders limit the contact between offender and victim and/or children and in situations of severe violence.

STANDARDIZED FAMILY ASSESSMENTS

- Screen IPV men for mental health and substance-related disorders with evidenced-based assessments that are standardized, widely used and relevant to treatment.
- Match offenders with co-occurring behavioral health and addiction with appropriate evaluation and treatment via licensed mental health providers (one size does not fit all). Psycho-educational approaches (FVEP/EVOLVE/EXPLORE) may be clinically contra-indicated.
- Provide a thorough evaluation of the type and frequency of IPV (e.g., physical violence, psychological, verbal, sexual violence) as well as the level of risk and treatment needs (Marlowe 2013) and typologies suggestive of treatment prognosis as indicated by Holtzworth-Munroe, Dutton, and Babcock's work. Regarding level of risk, refer to Appendix M for Marlowe's National Drug Court Institute's Assessment of Risk and Need Assessment Tools as a model system for use as an IPV risk-treatment needs assessment. Low- and high-risk offenders (e.g., clients with anti-social personality disorder, repeat offenders) should not be treated in the same group therapy as low-risk offenders. Low-risk offenders have poorer treatment outcomes when treated along with high-risk offenders. Research shows that treatment should be risk-relevant and appropriate, and indicates that high-risk offenders have more favorable treatment outcomes with more frequent court visits and judicial oversight.

- Assess multiple domains of social and functional impairment in men and women with co-occurring substance abuse and domestic violence.

EVIDENCE-BASED, SCIENCE-INFORMED INTERVENTIONS

- Consider both pharmacological and evidence-based behavioral treatment interventions as offenders of IPV often have complex and multiple behavioral health treatment needs beyond educational approaches.
- Consider alternative treatment goals designed to motivate offenders, such as motivational enhancement therapy, to reduce alcohol and or drug use as a form of harm reduction when offenders are struggling to abstain from alcohol and/or drug use.
- Use Integration of Care Models that increase the likelihood of treatment engagement and success. Assigning offenders to both educational programs and behavioral health treatments at multiple agencies is not effective (Bennett and Lawson 2002).
- Require standards for the number of offenders treated within a group therapy approach. The US Department of Veterans Affairs sets a limit of 3-5 offenders per group as clinically appropriate. Large classroom settings for offenders (e.g., greater than 10 offenders per group) with multiple behavioral health treatment needs are not clinically indicated (SAMHSA 1999).
- Families with children, drug/alcohol involvement, any weapon use, or physical injuries should be considered for immediate treatment engagement with each family member having treatment planning with little to no delay in access to care and wrap-around family violence treatment services. Also, homes with children should be considered high need for services.

Prevention

PUBLIC HEALTH ANNOUNCEMENTS

- Utilize the literature to identify the variables that lead to effective public health announcements (refer to Randolph and Viwanath 2004).
- Develop, implement, disseminate and monitor public health announcements to prevent family violence in the home. Specifically, monitor the effectiveness of a public health announcement in increasing victim and / or offender referrals to family violence hotlines for linkages to treatment.
- Evaluate the relationship of public health announcements to any changes in the number of calls and/or linkages to services (e.g., which public health announcements led to calls and linkages).

PROGRAMS

- Conduct a quantitative evaluation of the state's family violence prevention approaches, including DCF/IPV Programming and OEC/Nurturing Families Network, to determine their effectiveness at reducing family violence. The evaluation should include:

- Analyzing risk and need assessment tools used to determine victim and offender eligibility for intervention and prevention services
- Determining priority for providing services to victims and offenders based on level of risk
- Assessing treatment outcomes by comparing victims and offenders receiving services to those not receiving services (e.g., new victims and offenders who are referred and complete services versus new victims and offenders who are referred and do not attend and/or complete services)

OFFENDER EVALUATION

- Conduct a quantitative evaluation of recidivism rates of family violence offenders who have been incarcerated and received family violence treatment(s) while incarcerated or as a condition of their release.

Pilot Demonstration Project: Research Recommendations Pertaining to Future and Ongoing Effectiveness Studies of Connecticut's Family Violence Intervention Programs (e.g., Family Violence Diversionary Statute)

An investigation of current Connecticut intervention and prevention practices informed by a synthesis of current research referenced in the literature review of this report confirms that while a subsample of offenders benefit from involvement in family violence interventions offered in Connecticut, others do not. Given the potential for harm from misdirecting an individual to an intervention that is either insufficient or not appropriate, it is critically important to screen out those who are unlikely to benefit (e.g., psychiatric and substance use disorders) and re-direct these offenders to more appropriate treatments — licensed mental health facilities offering psychiatric care. It should be noted that the best available evaluation of the Court Support Services Division's three court-mandated family violence interventions (Cox & Rivolta 2014), the state's primary family violence prevention program for offenders, suggests that only one of the three models in use may reduce rates of family violence arrests compared to a matched non-treatment control group (e.g., one model showed statistically significant differences on new arrests). Furthermore, an important subgroup of offenders, i.e., those at highest risk for family violence, includes a substantial proportion who do not benefit from their designated court-ordered intervention. This group of offenders are re-arrested for new offenses related to family violence within one year of post-treatment. In general, the results of the Cox & Rivolta study should be interpreted with caution as the study lacked a standardized and comprehensive battery of baseline characteristics.

This evaluation, as well as this study's interviews and the focus group session with professionals who are knowledgeable about current Connecticut practices, indicate that some offenders are inappropriately offered diversion to family violence interventions, or are referred to family violence interventions inadequate for their levels of risk. Moreover, it was evident from the research that not all offenders receive adequate screening, especially with regard to psychiatric and substance use disorders, nor are they tracked or entered into a database systematically for determining treatment and program effectiveness.

It is recommended that the state develop the capacity to conduct ongoing research and evaluation of family violence prevention policies, programs and strategies through use of a multi-agency framework. The overriding goal of this effort is to ensure that the most effective treatment approaches are employed to reduce family violence as well as the overall cost of family violence to the state. It is suggested that the Office of Policy and Management take a leadership role, with support of the governor's office, in coordinating this effort across all branches of state government.

Additionally, it is recommended that a demonstration pilot project be undertaken to provide "proof of concept" based on this framework. The recommended demonstration pilot is focused on improving the screening of offenders charged with family violence to identify characteristics that are associated with recidivism in each of the Court Support Services Division's three family violence interventions, and developing an algorithm for better screening to match offenders with the most appropriate treatment. This effort includes merging data on offenders that would be available to the court, such as criminal history, DVSI-R and LSI-R assessment results, behavioral health diagnostic information, as well as data about an offender from other sources, including DMHAS, DCF and DOC. Merging of the data would need to be at the level of the individual offender, with attention to data security, and with removal of personal identifiers and other unique information that could potentially identify the offender or family members.

RECOMMENDED ACTIONS TO ESTABLISH THE FAMILY VIOLENCE PREVENTION RESEARCH AND EVALUATION FRAMEWORK

- Family Violence Prevention Advisory Committee: Appoint an advisory committee of relevant agencies, including DMHAS, DCF, DOA, OEC, DOC and the Judicial Branch, as well as family violence stakeholders, to identify research questions to address the effectiveness of current prevention policies, programs and strategies, including recommendations about research and evaluation needs included in this study.
- Family Violence Prevention Multi-Agency Working Group: Establish a multi-agency working group comprising relevant state agencies and the Judicial Branch to identify data sets needed to address the research questions posed by the Advisory Committee, procedures for merging the data sets, and appropriate protocols for accessing the merged data set.
- Family Violence Research Advisory Panel: An advisory panel consisting of experts with research expertise in related research areas and experience serving on scientific review committees should be appointed to provide independent advice on the conduct of relevant research and evaluation projects. Responsibilities of the panel should include:
 - o review research questions posed for the probability of conducting credible research based on available data
 - o review and recommend appropriate and relevant assessments to increase the integrity of data collected and managed
 - o advise on the research questions(s) to be studied
 - o advise throughout the research process, from selection of the researcher(s) through oversight of the research as it progresses through periodic review

- o continuously scan for new scientific developments in family violence interventions, and periodically compare the findings of past research on interventions that may be more effective than those currently in use, especially for individuals who have co-occurring mental health and addiction treatment needs and/or are at a higher risk for re-offending
- OPM should provide administrative support for the Family Violence Prevention Advisory Committee, the Family Violence Prevention Multi-Agency Working Group and the Family Violence Research Advisory Panel, including facilitating the merging of data from state agencies and the Judicial Branch, and ensuring ongoing compliance with protocols for accessing the merged data by state agencies and researchers.

RECOMMENDED ACTIONS FOR DEMONSTRATION PILOT

The recommended demonstration pilot project would conduct research to develop a screening algorithm based on recidivism among offenders that have participated in CSSDs family violence interventions, which by statute is Connecticut's main family violence intervention program. The research should measure the extent to which an algorithm using only data available to court personnel compares to an algorithm that also uses data from DMHAS, DCF and DOC. This comparison will allow for a determination as to whether information from other state agencies is needed for future screenings of family violence offenders, or if information currently available to the court is sufficient. For a research model outline, including research questions and tables detailing the relevant and comprehensive baseline and treatment outcome characteristics, see Appendix N.

- It is recommended that OPM prepare a draft Request for Qualifications (RFQ) to: identify a researcher(s) able to conduct analyses on the merged dataset to screen offenders from the CSSD's three court-mandated family violence interventions; prepare a template (i.e., scores) for review of the RFQ; and submit the template to the Family Violence Research Advisory Panel for comment.
- OPM should issue a RFQ for the purpose of conducting research related to the posed research questions. Researchers responding to the RFQ should submit their research protocol and timeline for review by the panel. This protocol should be approved (or exempted from review) by all relevant Institutional Review Boards, as well as by the involved state agencies.
- The Family Violence Research Advisory Panel should advise on the selection of a researcher(s) who best meets the qualifications for the purpose of the research to be conducted with OPM making the final selection decision.
- As the research progresses, the Family Violence Prevention Advisory Committee and the Family Violence Research Advisory Panel should receive periodic progress updates and the final report for comment.
- Based on the final report, and recommendations from the Family Violence Prevention Advisory Committee and the Family Violence Research Advisory Panel, OPM should facilitate actions for changes by relevant state agencies that are needed for screening and intervention placement, using a new algorithm based on the research findings. If additional information for screening is needed for decision-making (e.g., information on substance abuse from DMHAS or past family violence from DCF), a process for

obtaining that information (e.g., sending releases to a contact person at each agency) should be developed and instituted.

- Based on the results of this demonstration pilot project, the Family Violence Research Advisory Panel should identify additional research questions, such as a treatment outcome study, as appropriate for OPM's consideration and use in facilitating ongoing discussion of needed research for continuous improvement of Connecticut's family violence treatment programs.
- With the researcher and the Family Violence Prevention Research Advisory Panel, the Family Violence Prevention Advisory Committee should develop a protocol for ongoing monitoring of screening, intervention placement, and client outcomes.

CONCLUDING REMARKS

In summary, the literature is clear. Family violence is pervasive and children who witness abuse are likely to be victims and/or offenders, with co-occurring behavioral health disorders and medical problems. A high percentage of male adult offenders of IPV witnessed family violence and/or were abused in their home as children (Coker et al. 2005; Mitchell & Finkelhor 2001; Knight et al. 2013). Integration of care models, grounded in science, is needed to treat IPV and co-occurring behavioral health disorders. The US Health Care Reform Act initiatives highlight the need for this newer system of care. Treatment outcomes are likely to improve as the standards of care improve through implementation of changes in protocols that increase diagnostic evaluations, integrate care with evidence-based models, require limits to the number of offenders in a group treatment and require qualifications of clinicians who treat offenders (licensed and trained psychologists, social workers and/or psychiatrists). Moreover, protocols designed to reduce the incidence of children witnessing abuse should be a primary target at all levels of prevention and intervention.

REFERENCES

References cited in the Executive Summary can be found on page 84 of Section 6.0: Recommendations and Concluding Remarks.