DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD

ANNUAL LEGISLATIVE REPORT

Evidence-Based Practices for the Treatment and Management of Domestic Violence Offenders

DVOMB

A Report of Findings per 16-11.8-103(5.5)(a), C.R.S.

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Executive Summary

Pursuant to Section 16-11.8-103(5.5)(a), C.R.S.,[1] this annual report presents findings from an examination by the Domestic Offender Management Board (DVOMB) of best practices for the treatment and management of individuals who have committed domestic violence offenses. This report fulfills in part the requirements in Section 16-11.8-103(5.5)(a), C.R.S. and provides an update regarding the status of meeting the other new statutory mandates.

2021 Sunset Review and Reauthorization HB2022-1210

In FY2021-2022, the DVOMB underwent a Sunset Review by the Colorado Department of Regulatory Agencies (DORA). A sunset review is a periodic assessment of a state board or program to determine if that organization is meeting its statutory mandates and whether they should be continued by the state legislature. The DORA Sunset Report of the DVOMB provided a comprehensive review of the DVOMB regarding its functions, mandates, and programmatic data. The legislature considered the recommendations from DORA and added new mandates to the DVOMB as part of the reauthorization bill House Bill 2022-1210 which continues the DVOMB until 2027. This bill specified new mandates for the DVOMB to collect data, present an annual report and conduct compliance reviews on at least 10% of Approved Providers every two years.

Section 1: Research and Evidence-Based Practices

To identify the most current research- and evidence-based practices to date within the field of domestic violence offender treatment and management, the DVOMB conducted a literature review in support of ongoing committee work and the development of this report. Travers et al. (2021) conducted the most recent, comprehensive meta-analysis of domestic violence treatment and the only one to-date that examined adherence to the RNR model as a moderator of treatment outcome (recidivism rates following treatment). Travers et al. focused on more recent, contemporary, treatment approaches that were published from 2008 onwards. *Overall, the domestic violence treatments produced a positive treatment effect compared to no-treatment but one that was clearly moderated by degree of adherence to the RNR principles. Programs that fully adhered to the model had the greatest reductions in recidivism rate over 2 years follow-up, with a 7.0% recidivism rate for treated individuals versus 19.6% for untreated comparisons (k=2, n=479; OR=.30).* For programs that partially-adhered, the recidivism rate was 23.0% for treated individuals compared to 33.5% for untreated comparisons (k=3, n=8,851; OR=.58). There were few programs that were fully "one-size-fits-all" (i.e., did not adhere) and these did not produce significant treatment effects. More information about treatment effectiveness can be found in Section 1 of this report.

Section 2: Relevant Policy Issues and Recommendations

In Section 2 of this report, the DVOMB identified topics or areas of consideration needing legislative attention. The nature of these recommendations may not directly fall within the purview of the DVOMB. However, the complex field of domestic violence intersects with an array of different policy arenas, stakeholders, and institutions seeking to reduce the incidence of intimate partner violence. It is within this context that the recommendations aim at improving domestic violence prevention and intervention services accessible to all

[1] Notwithstanding section 24-1-136 (11)(a)(I), on or before January 31, 2023, and on or before each January 31 thereafter, the board shall prepare and present a written report to the house of representatives judiciary committee and the senate judiciary committee, or their successor committees.

Coloradoans. The recommendations of the DVOMB do not reflect the recommendations of the Department of Public Safety.

1. **Teen Dating Violence is a Precursor to Adult Intimate Partner Violence**

   The scope of teen dating violence is not adequately documented limiting the potential interventions to address this issue. The Board recommends exploring how cases of teen dating violence are identified in the juvenile court system and how many juveniles are adjudicated for offenses related to relationship abuse. The information will indicate whether legislative action is needed to bring Title 19 of the Colorado Revised Statutes into line with the adult system mandates for treatment. Sentencing mandates should include developmentally appropriate treatment and education for juvenile offenders. The lack of information regarding the scope of teen dating violence inhibits the development of services for victims and offenders as well as the use of the Best Practice Guidelines for Working with Youth Who Engage in Relationship Abuse, sentencing initiatives for youth that involve education, and early intervention and prevention strategies. Empirical data on the prevalence of teen dating violence may also encourage further partnering with community agencies already engaged in education and prevention work. However, there is a lack of treatment resources and the availability of juvenile treatment programs to incorporate these services would also need to increase.

2. ***Treatment Victim Advocate Confidentiality and Privilege***

   Treatment Victim Advocates share three main similarities with community-based advocates: crisis management, safety planning and resources align with community-based victim advocates. The DVOMB recommends enacting legislation as part of C.R.S. 16-11.8-103 that identifies Treatment Victim Advocates and defines their role to have the same level of confidentiality and privilege as a community-based victim advocate as defined in C.R.S. 13-90-107. Legislation could also be enacted as part of C.R.S. 16-11.8-103 that simply declares Treatment Victim Advocates as community-based victim advocate as defined in C.R.S. 13-90-107.

3. ***Referrals for Offender Treatment Evaluations and Services in Domestic Violence Civil Cases Without Criminal Findings: Challenges and Recommendations***

   The DVOMB *Standards and Guidelines* are specific to individuals who are convicted and sentenced according to § 16-11.8-103(4)(a)(II), C.R.S. for crimes which meet the statutory definition of domestic violence.[2] For cases that fall outside the purview of the DVOMB, Providers are not bound by the *Standards and Guidelines* and may exercise discretion regarding if and how to evaluate and treat individuals, including individuals referred solely by civil court order. It is important to note that domestic violence offender services are not intended or appropriate for victims of domestic violence. Addressing domestic violence is important not only for the safety of the victim, but also for the protection of any children involved within that family system. For a variety of reasons, domestic violence may be addressed in civil courts without concurrently being addressed in criminal courts. Victims seeking remedy following domestic violence frequently are not engaged with law enforcement or criminal legal systems and instead are solely involved in the civil legal system. Civil legal involvement may be via civil protection orders or domestic relations matters, where the abuse may be addressed. It is worthwhile to note that not all criminal acts are charged as domestic violence even when the behaviors fit a broader domestic violence

[2] C.R.S. 18-6-800.3(1): "Domestic violence" means an act or threatened act of violence upon a person with whom the actor is or has been involved in an intimate relationship. "Domestic violence" also includes any other crime against a person, or against property, including an animal, or any municipal ordinance violation against a person, or against property, including an animal, when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

definition. Frequently, victims of domestic violence are seeking help within civil systems in circumstances where the offender has not been criminally charged for abusive acts.

Due to its lack of statutory purview, the DVOMB cannot direct Providers as to whether or not and to what extent the DVOMB *Standards and Guidelines* should be applied to offenders referred through civil court orders. However, Providers have the training and expertise to address the presenting symptom profiles of people being referred regardless of whether the referral originates from a criminal or a civil context. The DVOMB is currently unable to promulgate any guidance to Providers because the board's purview is limited to criminal cases. As a result, there is a lack of standardization in how civil cases are approached and overseen with regard to the evaluation and treatment of domestic violence offenders. Changes in statute may alleviate these barriers by expanding the purview of the DVOMB in order to authorize its role in the creation of *Standards and Guidelines* for civil cases involving domestic violence.

Section 3: Milestones and Achievements

The following highlights some of the many additional achievements of the DVOMB in FY2021-2022:

- Managed six DVOMB committees
- Adjusted the way the DVOMB conducts business in response to the COVID-19 pandemic, while offering additional trainings and continuing all normal business in a virtual environment.
- Approved 80 applications for placement or continued placement on the DVOMB Approved Provider List during 2021.
- As of July 2022, there are 159 active and 16 not currently practicing treatment providers approved by the DVOMB in Colorado. Of those treatment providers, **130 are approved to work with female offenders** and **50 are approved to work with LGBTQ+ offenders.**
- Conducted 33 trainings virtually to over 1,417 attendees from across Colorado. These trainings covered a range of topics related to the treatment and supervision of individuals convicted of domestic violence offenses.
- Supported monthly Technical Assistance hours. On a monthly basis, DVOMB staff hosted two virtual, one-hour technical assistance sessions for approved providers. This allows staff to update providers on recent changes to the *Standards and Guidelines* as well as allowing providers to have questions answered.
- Contracted with Orange Circle Consulting to explore, study, and develop an outreach strategy to help reach the right people with the right tactics. This effort to create a strategy includes recruiting potential DVOMB Approved Providers with specific focus on diversity, equity, and inclusion.
- Implemented new statutory requirements and created systems for DVOMB Approved Provider to submit client data related to domestic violence offender services.

Efforts to Recruit New DVOMB Approved Providers

The Office of Domestic Violence and Sex Offender Management (ODVSOM) recognized a need to address the future recruitment and retention of Approved Providers participating in domestic violence and sex offense-specific

treatment. And in particular to enhance Provider diversity, and to ensure a sufficient and healthy workforce. Inhibiting factors include a competitive labor market for mental health professions, the additional stress of practicing in a forensic-legal context, and the nature of the therapeutic work, which can dis-incentivize individuals from becoming an Approved Provider. Orange Circle Consulting was recruited to complete an analysis of these recruitment and retention challenges, and provide recommendations to attract additional Providers. More specifically, Orange Circle Consulting was to conduct formative research to develop effective strategies to attract new providers to the field and retain existing providers. The resulting strategies could be implemented or supported by the SOMB and DVOMB, and shared with other stakeholders to enhance similar efforts for their agencies and professions. The project involved collecting survey data on individuals currently pursuing or working as a therapist to identify core values that may align with and motivate becoming an Approved Provider. The survey also sought to determine existing knowledge and perceptions about the Colorado SOMB and DVOMB approaches. Attention was paid to participant recruitment to ensure the sample represented people of Hispanic and African American identities. A second arm of the project involved interviews and focus groups with current Colorado SOMB and DVOMB stakeholders to develop an understanding of how existing Providers entered these fields of practice, and identify any potential barriers or disincentives to becoming or remaining in this field.

A full summary of the project findings is provided in Appendix D. Survey respondents indicated that key influences in choosing a mental health profession were the desire to help people and an understanding of the benefits of therapy. Respondents willing to consider becoming an Approved Provider were more likely to show interest in helping achieve victim safety through offender rehabilitation, helping to make positive changes at a community level, and learning about the intersection between psychology, law, and forensic practice. Respondents of Hispanic and African American identities indicated a high willingness to consider becoming an Approved Provider. Stakeholder participants indicated that many came into this field of work by accident rather than with intention. Most identified the desire to make a positive impact on individuals and communities as a key motivator, alongside a curiosity to learn and work in a forensic context. Practicing in a field with a strong emphasis on evidence-based practices was seen as positive. Almost all stakeholders described working with this client group as mentally and emotionally challenging, and highlighted that an additional element of professional liability and risk exists that is not perceived in general mental health settings.

For marketing and recruitment purposes, the project identified a range of potential audiences that could be targeted and noted that investments in internships and developing mentorship programs may help raise awareness within student training settings. Developing materials to showcase the positive aspects and outcomes of working with the client populations was also suggested as a strategy that could be effective in recruitment. Messaging that highlights the emphasis in the Colorado Standards and Guidelines on victim and community safety, evidence-based practices, EDI (equity, diversity, and inclusivity), and being responsive to people's cultural identities would appear to align with the motivating values and interests expressed by survey respondents and stakeholders. Identifying opportunities to reach out to trainees or current mental health professionals who are of Hispanic and African American identities seems pertinent. A public relations outreach effort with existing Approved Providers was also suggested.

Introduction

Purpose

Pursuant to Section 16-11.8-103(5.5)(a), C.R.S.,[3] this annual report presents findings from an examination by the Domestic Offender Management Board (DVOMB) of best practices for the treatment and management of individuals who have committed domestic violence offenses. This report fulfills the statutory mandate by providing:

1. A summary of emerging research- and evidence-based practices regarding evaluation, assessment, treatment and supervision strategies in the field of domestic violence offender management; and
2. A review of policy issues affecting the field of domestic violence offender management that the Legislature may wish to review for potential statutory change.

Additionally, this report documents the achievements from fiscal year 2021-2022 and current efforts being undertaken by the DVOMB.

Background of the Domestic Violence Offender Management Board

The Colorado Domestic Violence Offender Management Board (hereafter Board) was created by the General Assembly in the Colorado Department of Public Safety in July 2000 pursuant to § 16-11.8-103, C.R.S. The legislative declaration in the Board's enabling statute states that the consistent and comprehensive evaluation, assessment, treatment and continued monitoring of domestic violence offenders at each stage of the criminal justice system is necessary in order to lessen the likelihood of re-offense, to work toward the elimination of recidivism and to enhance the protection of current and potential victims (§ 16-11.8-101 C.R.S.). The Board was charged with the promulgation of standards for the evaluation, assessment, treatment, and monitoring of domestic violence offenders defined in § 16-11.8-102, C.R.S. (hereafter Standards and Guidelines) and the establishment of an application and review process for approved providers who provide services to domestic violence offenders in the state of Colorado. The evaluation, assessment, treatment, and behavioral monitoring of domestic violence offenders shall only be provided by those individuals whose name appears on the DVOMB Approved Provider List pursuant to § 16-11.8-104(1).

[3] Notwithstanding section 24-1-136 (11)(a)(I), on or before January 31, 2023, and on or before each January 31 thereafter, the board shall prepare and present a written report to the house of representatives judiciary committee and the senate judiciary committee, or their successor committees.

The Board is committed to carrying out its legislative mandate to enhance public safety and the protection of victims and potential victims through the development and maintenance of comprehensive, consistent and effective standards for the evaluation, assessment, treatment and behavioral monitoring of adult domestic violence offenders. The Board will review literature and research on the most effective methods for intervening with domestic violence offenders and to identify best practices in the field.

In 2010, the *Standards and Guidelines* were revised to more closely adhere to the principles of risk, need, and responsivity[4] (RNR) (Andrews & Bonta 2010; Andrews & Dowden, 2006; Latessa & Lowencamp, 2006; Radatz & Wright, 2015). This change in the *Standards and Guidelines* eliminated the previous minimum length of 36 weeks for all offenders and instituted a differential treatment model with three different risk categories. Offender risk levels are assessed using a research-informed instrument, the Colorado Domestic Violence Risk and Needs Assessment (DVRNA) developed by the DVOMB. The DVRNA instrument, composed of 14 risk factors, is designed to identify a risk level that then corresponds to the intensity of treatment that should be delivered. Based on the results of the DVRNA, an offender may be placed into one of three levels of treatment intensity: low risk (Level A), moderate risk (Level B), or high risk (Level C). A DVOMB treatment provider who is trained on the use of the DVRNA scores the instrument as part of a comprehensive evaluation prior to the start of treatment, using official record data and information obtained while interviewing the offender.

The *Standards and Guidelines* are specifically designed to establish a framework for the systematic risk management, assessment, and clinical treatment of domestic violence offenders. The *Standards and Guidelines* support a comprehensive range of therapeutic modalities and interventions for identified treatment needs, along with behavioral monitoring strategies for improved supervision based on risk level and protective factors. This systemic approach fulfills a two-fold purpose: (1) managing and reducing violent and abusive behavior, while also (2) promoting protective factors that enable an offender's success. The *Standards and Guidelines* are now continuously revised and posted on the DVOMB website, updating each section with new changes as they are approved.

The *Standards and Guidelines* support a coordinated approach in which a Multi-Disciplinary Treatment Team (MTT) provide an individualized treatment and supervision plan that targets both psycho-social deficits and potential risk factors, while concurrently building upon the resiliency and positive traits inherent in the offender. To be effective, this approach must include interagency and interdisciplinary teamwork. The MTT consist of a supervising officer, treatment provider, treatment victim advocate, and other adjunct professionals, where applicable. MTT members, independent of each other, possess critical expertise and knowledge that once shared can enable improved decision-making among the team. This enhances not only public safety but the supervision and accountability of the individual under supervision.

The *Standards and Guidelines* are based on research and best practices for managing and treating domestic violence offenders. To the extent possible, the DVOMB has based the *Standards and Guidelines* on evidence-based practices in the field. However, the specialized field of domestic violence offender management and treatment is still developing and evolving. Professional training, literature reviews, and documents from relevant professional organizations have also been used to direct the *Standards and Guidelines*. The DVOMB will continue to modify the *Standards and Guidelines* periodically on the basis of new empirical findings.

[4] Risk – Services provided to offenders should be proportionate to the offenders' relative level of static and dynamic risk (i.e., low, moderate, or high risk) based upon accurate and valid research-supported risk assessment instruments; Need - Interventions are most effective if services target criminogenic needs (both social and psychological factors) that have been empirically associated with recidivism; and, Responsivity - Effective service delivery of treatment and supervision requires individualization that matches the offender's culture, learning style, and abilities, among other factors.

In part, the DVOMB stays current on research through the work of its active committees. These committees meet on a regular basis and report back to the DVOMB to inform potential modifications to the *Standards and Guidelines*. The following is a list of the DVOMB committees.

1. Executive Committee
2. Application Review Committee
3. Diversity, Equity, and Inclusion Committee
4. Standards Revisions Committee
5. Victim Advocacy Committee
6. Training Committee (in collaboration with the Sex Offender Management Board)

Report Organization

This annual legislative report consists of four sections. The first section provides a summary of the current and relevant literature concerning research and evidence-based practices. The second section highlights relevant policy issues. The third section highlights the recent achievements of the DVOMB. This section will include priorities identified by the DVOMB, which will be addressed in 2023. The fourth and final section provides the future goals and directions of the DVOMB.

Section 1: Research and Evidence-based Practices

Principles of Effective Intervention (PEI) and Domestic Violence Treatment Effectiveness

To improve the effectiveness of domestic violence treatment, researchers and practitioners have recommended that domestic violence offender treatment adhere to the Risk-Need-Responsivity (RNR) principles of effective practice (Radatz, Hansen, & Thomasson, 2020; Richards & Murphy, 2018; Travers, McDonagh, Cunningham, Armour, & Hansen, 2021). Although the RNR model was initially developed and applied in the general offender field, it is now applied broadly. It is an applicable and promising paradigm for domestic violence offender treatment, although aspects of the model require further study for domestic violence offenders (Bonta & Andrews, 2017) and several critiques of the model highlight continuing need for development (e.g., Thornton, 2016; Ward & Beech, 2015; Ward & Marshall, 2004).

The core principles of the model are well known. In brief, these stipulate that treatment should be proportional to the offender's risk to reoffend (Risk Principle), focus on the offender's dynamic criminogenic needs (Need Principle), and be delivered in a way that promotes engagement and learning (Responsivity Principle), given what is generally known about program effectiveness (General Responsivity Principle) and the offender's personal attributes (Specific Responsivity Principle) (Andrews, Bonta, & Hoge, 1990: Bonta & Andrews, 2017). There are other, lesser well-known, principles of the RNR model in the "expanded" version (Andrews, Bonta & Wormith, 2011; Bonta & Andrews, 2017) that canvass the guiding norms underpinning treatment (e.g., ethical practice), the role of structured assessment, other recommended therapeutic and programmatic features, and organizational features that facilitate the effective implementation of treatments.

Summary of Literature and Research

Travers et al. (2021) conducted the most recent, comprehensive, meta-analysis of domestic violence treatment and the only one to-date that examined adherence to the RNR model as a moderator of treatment outcome (recidivism rates following treatment). Travers et al. focused on more recent, contemporary treatment approaches that were published from 2008 onwards. Overall, the domestic violence treatments produced a positive treatment effect compared to no-treatment but one that was clearly moderated by degree of adherence to the RNR principles. Programs that fully adhered to the model had the greatest reductions in recidivism rate over 2 years follow-up, with a 7.0% recidivism rate for treated individuals versus 19.6% for untreated comparisons (k=2, n=479; OR=.30). For programs that partially-adhered, the recidivism rate was 23.0% for treated individuals compared to 33.5% for untreated comparisons (k=3, n=8,851; OR=.58). There were few programs that were fully "one-size-fits-all" (i.e., did not adhere) and these did not produce significant treatment effects.

Gannon, Olver, Mallion, and James (2019) also conducted a meta-analysis regarding the effectiveness of specialized psychological treatments for offending with an added focus on staff and program moderators of that effectiveness. Findings were separated for domestic violence treatment, alongside sex offending and general violence prevention treatments. Gannon et al. found the domestic violence recidivism rate over an average 5-year follow-up was 15.5% for treated individuals and 24.2% for untreated comparisons (k=14, n=9,845; OR=.65). *Gannon et al. found preliminary evidence for better treatment effectiveness in programs that provided supervision and that had a psychologist (qualified practitioner) consistently present during program delivery, which supports the notion that program integrity is important for program effectiveness (LeBlanc & Mong, 2021)*. Overall, Gannon et al.'s meta-analysis supports the findings from Travers et al. (2021), but notably did this with little overlap between the studies included. While the overall effect size was comparable between the two meta-analyses, Travers et al. demonstrated greater effects were evident when programs fully-adhered to the RNR principles.

Other recent meta-analyses of domestic violence treatment effectiveness are also noteworthy. Wilson, Feder, and Olaghere (2021) updated an earlier meta-analysis (Feder et al., 2008; Feder & Wilson, 2006) of domestic violence treatment for court-mandated males convicted of misdemeanor domestic violence charges. Wilson et al. found results favored treatment but were not statistically significant and thus raised concerns about the effectiveness of such court-mandated treatment. The inclusion criteria for this meta-analysis were narrower than either Travers et al. (2021) or Gannon et al. (2019) and resulted in all but one study being from 2003 or earlier. Thus, one limitation is that it is unclear whether the studies in this meta-analysis reflect current court-mandated domestic violence treatment programs as many are likely to have incorporated updates in the ensuing years. The meta-analysis also reinforces Travers et al.'s finding that one-size-fits-all programs do not have strong treatment effects.

Cheng and colleagues (2021) meta-analyzed published domestic violence treatment studies and found, in contrast to Wilson et al. (2021), treatment was effective at reducing domestic violence and general recidivism. Cheng et al.'s meta-analysis included more recent published evaluations and some prison-based program evaluations. As well, it also used slightly more conservative recidivism measures (i.e., charges/arrests/convictions). A consistent finding across Wilson et al. and Cheng et al. were that smaller treatment effects were found in experimental (randomized controlled) studies compared to the quasi-experimental (matched controlled) studies. As well, no effect was found when survivors' reports of abusive behavior were assessed, raising the question of whether criminalized domestic violence is a narrower measure of outcome than the broader range of abusive behavior characteristic of domestic violence.

Treatment Intensity, Format, And Setting

Gannon et al.'s (2019) meta-analysis examined the extent of a range of treatment program variables moderated the effectiveness of domestic violence treatments. Few conclusions were possible as almost all programs were provided in groups, mostly in a closed format, in the community, and of less than 100 hours duration. Some information about treatment intensity is possible to be gleaned from individual studies. Stewart et al.'s (2014) evaluation of the Correctional Services of Canada family violence prevention program indicated the high intensity program was approximately 200 hours of prison-based group work delivered over 4-6 months (i.e., 78 sessions of 2-3 hours per session, plus 10 individual sessions). The moderate intensity program was approximately 75 hours delivered over 2 months (25 sessions of 2-3 hours, plus at least 3 individual sessions). As indicated above, only the high intensity program had a significant effect on domestic violence recidivism over one-year follow-up. Blatch et al. (2016) indicated the Australian Domestic Abuse Program (DAP) was approximately 40-50 hours of community-based group work delivered over 10 weeks to domestic violence offenders assessed medium-to-high risk on the Level of Service Inventory - Revised (LSI-R; Andrews & Bonta, 1996). Similarly, Bloomfield and Dixon (2015) described the England-Wales community-based group moderate intensity domestic violence programs as involving

about 50 hours of group sessions plus 9-13 hours of individual sessions delivered over 9-13 weeks or 26 weeks in either closed or open group format.

In a small randomized clinical trial that compared group and individual formats of cognitive-behavioral treatment for domestic violence, Murphy et al. (2020) found, contrary to expectations, that the group program produced consistently equivalent or greater treatment benefits than the individual programs. Murphy et al. noted that the individual format created challenges for agenda setting, homework, and formal aspects of relationship skills training that were not as evident in the group format.

The therapeutic model underpinning a treatment program lays out an understanding of the causes of domestic violence, the role the offender plays in perpetrating and preventing domestic violence, the related targets for treatment and process of change, and the therapeutic methods that are applied to bring about change (Ward & Marshall, 2004). It ought to incorporate the causal (dynamic) risk factors that account for domestic violence (Bonta & Andrews, 2017; Douglas & Skeem, 2005; Mann, Hanson, & Thornton, 2010) and provide an integrated explanation of how these result in domestic violence (Cording, Beggs-Christofferson, & Grace, 2016; Mann et al., 2010; Ward & Beech, 2015). The therapeutic model is important as a mechanism for "framing" the intervention for the offender and others (e.g., therapists, victims, and community) and operates as a form of meta-communication about the nature of domestic violence and what constitutes appropriate treatment to change domestic violence (Cotti et al., 2020).

Several studies have directly compared the effectiveness of differing therapeutic approaches, particularly Duluth programs[5] and cognitive-behavioral programs. Cotti, Foster, Halyely and Rawski (2020) compared the Duluth and cognitive-behavioral diversion treatment programs for Wisconsin domestic violence offenders (men and women) using a field experimental design. Overall, the cognitive behavioral program had a 9% lower post-treatment domestic violence reoffense rate than the Duluth program; for men only the difference was 14%. Another finding from this study was that the drop-out rate for the Duluth program was 47.6% compared to 32.5% for the cognitive-behavioral treatment program. In another recent study, McNeeley (2019) also found a Duluth model, prison-based, domestic violence program had no impact on multiple measures of violent and general recidivism among released offenders in Minnesota.

In a meta-analysis, *Miller, Drake, & Nafziger (2013) identified 9 United States and Canadian domestic violence treatment studies (k=11) with robust methodologies and found that when all treatments were combined together there was no evidence of a treatment effect. However, when treatments were separated into those based on the Duluth model and those based on non-Duluth models, a significant effect was found for non-Duluth treatment only. The estimated reduction in domestic violence recidivism for the non-Duluth treatments was 15% (which equated to a 33% overall reduction in domestic violence recidivism compared to the base rate).*

[5] The Duluth model is based on feminist and sociological theories that propose intimate partner violence results from societal influences that reinforce patriarchal cultural norms. The programs are group psychoeducational interventions that focus on exploring power and control within relationships (the power and control wheel) and changing men's beliefs about their privilege in society and the subservient, position of women to be more egalitarian. A range of healthy relationships skills are typically covered (Babcock et al., 2016).

Motivational Enhancement

Santirso, Gilchrist, Lila, and Gracia (2020) reviewed the effectiveness of interventions for domestic violence offenders that included motivational enhancement[6]; only studies using a randomized clinical trial (experimental) design were included. The review highlighted the diversity of motivational enhancement interventions incorporated into domestic violence treatment programs to-date. While most incorporated personalized feedback to participants about their domestic violence behavior, several included extended motivational interviewing or experiential activities designed to advance participants along the stages of change[7], while others involved preparatory sessions to build the working alliance or increase participants' skills to engage in treatment. These experiential activities typically rely on group processes focused on establishing norms (i.e., acceptance, maintaining confidentially, group cohesiveness, willingness to self-disclose and accepting feedback). Yet another program emphasized personal and program goal-setting. While some programs added a single motivational enhancement session, others added 3-6 sessions, and about half added 16-40 sessions. Santirso et al. found motivational enhancement had a large positive effect on program drop-out and increased intervention dose. The effect on official and self-reported domestic violence was more equivocal.

Soleymani, Britt, and Wallace-Bell (2018) recently descriptively reviewed published evaluations on domestic violence programs that included motivational enhancement interventions. They identified five studies between 1980-2017 that related to four independent programs. The review found that the addition of motivational interventions increased treatment engagement and completion, particularly in those individuals at an earlier stage of change. Any impact on post-treatment domestic violence was less clear, however, although one study found a brief motivational intervention increased personal responsibility (internal attributions) for domestic violence. Similarly, Lila and colleagues (2018) found adding a relatively brief individualized motivational intervention to a standard domestic violence program resulted in participants having higher attendance (treatment dose), and advancing through more stages of change, as well as self-reporting less physical violence and having a greater reduction in recidivism risk scores. No differences in official recidivism rates were found, however, the short follow-up timeframe may have obscured any longer-term recidivism effects.

In another study (not included in the Soleymani et al. review), Connors, Mills, and Gray (2012) examined the interaction between motivation to change and program progress and found greater motivation was associated with greater engagement, more improvement on criminogenic needs, and a faster rate of learning/change over the course of the program. Further, motivation and criminogenic skills deficits appeared to interact with those with low motivation at the beginning of treatment also showing greater deficits. Maldonado and Murphy (2021) also found readiness to change interacted with referral status and personality disorder traits. They found greater readiness to change predicted engagement and better treatment outcome in individuals who were court-mandated and/or higher (rather than lower) in borderline or antisocial personality traits. These studies highlight that low motivation often reflects other criminogenic deficits or problematic personality traits.

Taken together, the research indicates that adding motivational enhancement to standard domestic violence treatment shows good promise for addressing, at least some, treatment responsivity challenges. It appears to lessen treatment drop-out, increase the amount of treatment received through greater session attendance, and facilitate moving forward in the

[6] Motivational enhancement includes a number of approaches designed to increase motivation for positive behavior changes or activate intrinsic motivation toward healthy states. These include motivational interviewing strategies, strengths-based treatments, stage-of-change based treatments.

[7] The Stages of Change Model (Prochaska, DiClemente, & Norcross, 1992) describes readiness to change behavior from pre-contemplative through active and maintenance phases. It was developed in the substance addiction field but has been applied widely within behavioral health and offender rehabilitation. In the earliest stages of the model there is pre-contemplation (i.e., there is no intention to take actions to work on treatment needs or change) and contemplation (i.e., there is some stated intention to take actions to work on treatment needs or change but there also ambivalence). The model contends that behavior changes occurs in a stage-like manner and that techniques should be tailored to the stage of the client.

process (stages) of change. The extent this translates into reductions in domestic violence recidivism is less clear though and requires further systematic research.

Updates regarding Implementation of Data Collection Project

As of the date of this publication, the DVOMB has launched a data collection system for the purpose of gathering empirical data from DVOMB Approved Treatment Providers to be used to evaluate and improve upon the DVOMB *Standards and Guidelines*. These mandates are enumerated in C.R.S. § 16-11.8-103 and (4)(a)(IV) and (5.5) and directed the DVOMB to begin collecting data by January 1st, 2023. The statutory mandate directs the DVOMB to collect data on (a) the number of people who received domestic violence offender treatment in the preceding year, the number of those who successfully completed the treatment, the number of those who did not complete the treatment, and the number of those who reoffended and were removed from treatment.

In preparation of the meeting January 1st, 2023 implementation date, the DVOMB reviewed and revised its data collection plan (see Appendix A) and a total of eight trainings were offered to DVOMB Approved Provides about the requirements to submit data. DVOMB Approved Providers will have the option of submitting data through the Provider Data Management System (PDMS) or through a private organization called ReliaTrax which is an electronic health record system. The DVOMB anticipates that the next report for fiscal year 2022-2023 will provide an initial baseline understanding of the data and the degree to which Providers are complying with the requirement to submit data.

Section 2: Relevant Policy Issues and Recommendations

Background

Pursuant to HB2022-1210, the sunset renewal of the DVOMB included language that permits the DVOMB to make policy recommendations to the legislature as part of its annual report. The following section puts forth recommendations the DVOMB identified as topics or areas of consideration needing legislative attention. The nature of these recommendations may not directly fall within the purview of the DVOMB. However, the complex field of domestic violence intersects with an array of different policy arenas, stakeholders, and institutions seeking to reduce the incidence of intimate partner violence. It is within this context that the recommendations aim at improving domestic violence prevention and intervention services accessible to all Coloradoans. The recommendations of the DVOMB do not reflect the recommendations of the Department of Public Safety.

Teen Dating Violence is a Precursor to Adult Intimate Partner Violence

Teen dating violence (TDV) continues to be a pressing issue in Colorado. Emerging research in the field of intimate partner violence indicates that the onset of abusive behaviors can and do start during adolescence (Johnson, Giordano, Manning, & Longmore, 2015). In fact, according to the Healthy Kids Colorado Survey[8], 1 in 10 Colorado high schoolers reported being physically hurt on purpose by someone they were dating in 2019. Shorey and colleagues' (2017, p. 275) reported that "as many as 20% of adolescents are victimized by or perpetrate physical TDV" annually in the United States (U.S.), and that these victims have higher depressive and posttraumatic stress symptomatology, alcohol and drug use, risky sexual behavior, and suicidal ideation (compared to their non-TDV victimized peers).

Early intervention and prevention of intimate partner violence is critical at the early stages of adolescent development. However, youth under the age of 18 who engage in relationship abuse in their dating relationships do not fall under the criminal definition of domestic violence. This is because domestic violence is codified in

[8] Healthy Kids Colorado Survey (HKCS) and Colorado Healthy Schools Smart Source (Smart Source), are Colorado's widely-administered surveys on the health and well-being of young people and school health policies and practices that support youth health. Data from HKCS and Smart Source are complementary and can be used together to provide a more complete picture of youth and school health. The surveys, conducted in the fall of odd-numbered years, are supported by the Colorado Department of Public Health and Environment (CDPHE), the Colorado Department of Human Services (CDHS), the Colorado Department of Public Safety (CDPS), the Colorado Department of Education (CDE), and an advisory group of state and local partners. The surveys are administered by a team of researchers at the Colorado School of Public Health (CSPH) at the University of Colorado Anschutz Medical Campus. CDPHE analyzes aggregated statewide and regional survey results, while the CSPH Survey Team aids schools and districts with accessing and interpreting their local results.

Title 18 of Colorado Revised Statutes (C.R.S.) which pertains to adults. There are therefore limited interventions and treatment options for these youth in Colorado despite the fact that domestic violence cases make up approximately 15 percent of all criminal filings in county, district and juvenile courts each year (Flick & English, 2016). Unlike adult domestic violence offenders, there is no mandate for youth who engage in abusive, harmful, and/or illegal acts toward a dating partner to receive treatment that is developmentally appropriate and that addresses dynamics of coercive control.

It is within this context that Violence Free Colorado and various state agencies collaborated with nonprofit partners and individuals to develop a new set of guidelines to work with youth ages 10-17 who engage in relationship abuse. These guidelines address a critical gap in services for youth by offering information and guidance to professionals who work in education, mental health, and juvenile justice and could provide treatment to this population. The Guidelines offer best practice recommendations that are informed by research for working with juveniles.

Recommendation

The scope of teen dating violence is not adequately documented limiting the potential interventions to address this issue. The Board recommends exploring how cases of teen dating violence are identified in the juvenile court system and how many juveniles are adjudicated for offenses related to relationship abuse. The information will indicate whether legislative action is needed to bring Title 19 of the Colorado Revised Statutes into line with the adult system mandates for treatment. Sentencing mandates should include developmentally appropriate treatment and education for juvenile offenders. The lack of information regarding the scope of teen dating violence inhibits the development of services for victims and offenders as well as the use of the Teen Dating Violence Guidelines, sentencing initiatives for youth that involve education, and early intervention and prevention strategies. Empirical data on the prevalence of teen dating violence may also encourage further partnering with community agencies already engaged in education and prevention work. However, the lack of treatment resources and the availability of juvenile treatment programs to incorporate these services would also need to increase.

Treatment Victim Advocate Confidentiality and Privilege

The DVOMB *Standards and Guidelines* support a coordinated approach in which a Multi-Disciplinary Treatment Team (MTT) for individuals who have committed domestic violence offenses, and provide an individualized treatment and supervision plan that address risk factors based on problematic behaviors and cognitions, while concurrently building upon the resiliency and positive traits inherent in the person. To be effective, this approach must include interagency and interdisciplinary teamwork. The MTT commonly consist of a supervising officer, treatment provider, a treatment victim advocate, and other adjunct professionals, where applicable. MTT members possess critical expertise and knowledge that once shared can enable improved decision-making among the team. This enhances not only public safety but the supervision and accountability of the offender. MTTs participate in decision-making through consensus throughout the treatment process for offenders, including the initial level placement in treatment, any possible change in level of offender treatment, treatment plan reviews, and discharge.

Treatment Victim Advocates (TVA) serves as an important role to individuals who have experience harm by providing information, support, and resources. After a domestic violence offender has been referred for evaluation and treatment services, a TVA attempts to contact the victim of record. Victims are not required to respond or engage with the TVA. Victims have the right to determine the extent to which they would like to be informed of an offender's status during the treatment process, and the extent to which they would like to provide input about the offender treatment process.

The DVOMB *Standards and Guidelines* prescribe the role, qualifications, and duties of TVAs in Section 7.0. These duties include:

- Contacting victims and discuss safe modes of communication, offering a general overview of the domestic violence offender treatment process, offering general information about domestic violence (such as warning signs and risks), discussing safety issues, and offering resources and referrals as needed.

- Serving as a bridge between victims and MTTs, participating in case problem-solving, and educating MTTs on trauma-informed considerations for victims.

- Maintaining confidentiality and being identified as mandatory reporters of known or suspected child abuse and abuse of elders and at-risk adults.

- Representing victim experiences and perspectives, whether or not a victim has been contacted, and whether or not a victim chooses to share information with an MTT.

- Explaining confidentiality and the limitations of their confidentiality, which includes mandatory reporting requirements, as well as victim choices and impacts about sharing information with the DVOMB Approved Provider or the entire MTT.

- Sharing information with victims about offender attendance, progress in treatment, and with treatment goals, changes in risk, and discharge planning.

In Colorado, victim advocacy is distinguished in three different ways: (1) community-based victim advocacy, (2) system-based advocacy, and (3) treatment victim advocacy. Community-based victim advocates work for organizations that offer services for people experiencing domestic violence, sexual assault, stalking, and sometimes legal advocacy. Community-based advocates provide support, safety planning, crisis intervention, information and referrals to services for survivors. Information shared by a survivor with a community-based victim advocate is protected by privilege and there is a duty for community-based advocates to maintain confidentiality when working with survivors. This privilege and duty to maintain confidentiality is enumerated by C.R.S. 13-90-107 and serves as an important safeguard for survivors. Community-based advocates cannot be compelled to disclose information from a survivor or that a survivor has sought the support of a community-based advocate.

System-based advocates operate within the criminal legal system such as law enforcement agencies, District or City Attorneys' Offices, probation, or parole. The role of a system-based advocate is to provide advocacy to a victim within the context of a criminal case. In Colorado, the Victims Right Act[9] (VRA) outlines the communications which victims of certain crimes are entitled to and system-based advocates work to comply with the VRA requirements. System-based advocates differ from community-based advocates in that any information shared by a crime victim with a system-based advocate is subject to subpoena and can be used by the legal system in the proceedings of a criminal case.

Unlike community-based victim advocates and system-based advocates that are defined by statute, the function and authority of a TVA is solely defined by the DVOMB *Standards and Guidelines*. The enabling legislation of C.R.S. 16-11.8-103 requires the DVOMB to establish Standards for the evaluation, assessment, and treatment of domestic violence offenders. As part of that statutory mandate, the DVOMB has identified the need for post-conviction victim advocacy services that are integrated with the treatment process. It is under this authority that the DVOMB created and defined Treatment Victim Advocacy. As a result, this role of the TVA is limited to within the statutory parameters of the DVOMB which presents several challenges.

[9] CRS: 24-4.1-301-304

The level of confidentiality and privilege for TVAs is reliant on the DVOMB *Standards and Guidelines*. The authority to establish *Standards and Guidelines* which involves matters of victim confidentiality and privilege are not within the purview of the DVOMB. The absence of any specific statutory provision calls into question whether the protections afforded for community-based advocates are extended to TVAs. This becomes problematic in rural communities when community-based advocates take on the role of a TVA. The role differentiation and the differences in confidentiality limitations between community-based advocates and TVAs can present a multi-layered risk for a community-based domestic violence organization to operate as TVAs. Risks include violating the confidentiality and privilege community-based domestic violence advocates have, protection from records being subpoenaed, and could impact funding due to the differences in confidentiality. Additionally, the lack of a statutory definition of TVAs has made it challenging to recruit and retain TVAs to work with DVOMB Approved Providers.

Recommendation

Treatment Victim Advocates share three main similarities with community-based advocates: crisis management, safety planning and resources align with community-based victim advocates. The DVOMB recommends enacting legislation as part of C.R.S. 16-11.8-103 that identifies Treatment Victim Advocates and defines their role to have the same level of confidentiality and privilege as a community-based victim advocate as defined in C.R.S. 13-90-107. Legislation could also be enacted as part of C.R.S. 16-11.8-103 that simply declares Treatment Victim Advocates as community-based victim advocate as defined in C.R.S. 13-90-107.

Referrals for Offender Treatment Evaluations and Services in Domestic Violence Civil Cases Without Criminal Findings: Challenges and Recommendations

The DVOMB *Standards and Guidelines* are specific to individuals who are convicted and sentenced according to § 16-11.8-103(4)(a)(II), C.R.S. for crimes which meet the statutory definition of domestic violence.[10] For cases that fall outside the purview of the DVOMB, Providers are not bound by the *Standards and Guidelines* and may exercise discretion regarding if and how to evaluate and treat individuals, including individuals referred solely by civil court order. It is important to note that domestic violence offender services are not intended or appropriate for victims of domestic violence. There are significant differences between criminal and civil courts in how they may address the domestic violence allegations. These differences include variance in how domestic violence is defined, the burden of proof required for a finding of domestic violence, how institutional systems approach and respond to domestic violence cases, and the resources available for oversight. Specifically, DVOMB stakeholders have raised concerns about the civil legal system's lack of infrastructure for accountability and multi-disciplinary oversight of offenders, whereas such elements do exist within the criminal legal system and are identified as central to appropriate intervention. As a result, DVOMB Approved Providers have expressed reservations about working with offenders who fall outside of the *Standards and Guidelines*.

Addressing domestic violence is important not only for the safety of the victim, but also for the protection of any children involved within that family system. The negative intergenerational impact of domestic violence on children has been demonstrated unequivocally in the literature (Ireland and Smith 2009; McDonald et al. 2006). For children who see a caregiver harmed, who may be present for and injured during violent incidents, and who may be subject to developmentally inappropriate expectations by an offender parent, these experiences create toxic stress. Children are considered a vulnerable population for which experiencing domestic violence during

[10] C.R.S. 18-6-800.3(1): "Domestic violence" means an act or threatened act of violence upon a person with whom the actor is or has been involved in an intimate relationship. "Domestic violence" also includes any other crime against a person, or against property, including an animal, or any municipal ordinance violation against a person, or against property, including an animal, when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

formative and developmental years can increase risk factors associated with important developmental domains (family-of-origin disadvantage, parent stressors, adolescent stressors, antisocial behaviors, family violence, delinquent peers, early intimate relationships, and educational experiences).[11]

For a variety of reasons, domestic violence may be addressed in civil courts without concurrently being addressed in criminal courts. Victims seeking remedy following domestic violence frequently are not engaged with law enforcement or criminal legal systems and instead are solely involved in the civil legal system. Civil legal involvement may be via civil protection orders or domestic relations matters, where the abuse may be addressed. It is worthwhile to note that not all criminal acts are charged as domestic violence even when the behaviors fit a broader domestic violence definition. Frequently, victims of domestic violence are seeking help within civil systems in circumstances where the offender has not been criminally charged for abusive acts.

Due to its lack of statutory purview, the DVOMB cannot direct Providers as to whether or not and to what extent the DVOMB *Standards and Guidelines* should be applied to offenders referred through civil court orders. However, Providers have the training and expertise to address the presenting symptom profiles of people being referred regardless of whether the referral originates from a criminal or a civil context.

The DVOMB is uniquely positioned to provide structure and support that enables Providers to accept offenders referred from civil cases and for TVAs to participate in these matters. Without said support, there is a large gap in services leaving systems unable to provide for families impacted by domestic violence. Shortfalls in the civil legal systems can allow these issues to be overlooked and the current system is can be misused to the detriment of the victim and their children.

Recommendation

1. *Broaden the purview of the DVOMB to include domestic violence cases arising from civil courts*

Much has changed in the understanding of domestic violence in the years since 2008 when the DVOMB enabling statutes were last modified. Requests for Providers to work with offenders in civil cases are increasing, and Providers want guidance to do so effectively. Providers represent a qualified body of professionals who are uniquely trained and skilled to provide services with this population. The DVOMB is currently unable to promulgate any guidance to Providers because the board's purview is limited to criminal cases. As a result, there is a lack of standardization in how civil cases are approached and overseen with regard to the evaluation and treatment of domestic violence offenders. Additionally, access to funding for these services is often limited. Changes in statute may alleviate these barriers by expanding the purview of the DVOMB in order to authorize its role in the creation of *Standards and Guidelines* for civil cases. This would require broadening the definitions in § 16-11.8-102(2), C.R.S. to include a more comprehensive definition of a domestic violence offender to include someone who engages in domestic abuse as defined in § 13-14-101(2), C.R.S. or domestic violence as defined in § 14-10-124 (1.3)(a), C.R.S. This would also necessitate clarifying the DVOMB's purview in § 16-11-103(4)(a)(2), C.R.S.

2. *Update the Best Interest of the Child Standard to align with requirements to use a DVOMB Approved Provider and Ensure Compliance*

Currently, the Best Interest of the Child Standard (§ 14-10-124, C.R.S.), used to address parenting time and decision-making in cases involving allocation of parental responsibility and care and control of minor children in civil protection order matters, includes domestic violence offender evaluation and treatment as something a

[11] A 2015 study by Smith et al. found that the cumulative effect of risk factors equated to a person being 1.25 times more likely to commit interpersonal violence (IPV) in emerging adulthood and 1.18 times more likely to commit IPV in adulthood, regardless of gender. The negative short- and long-term impacts on children underscore the importance of meaningful intervention with offenders. Treatment for domestic violence offenders requires specialization when brought to the attention of caseworks, judicial officers, and attorneys.

court may order if a party is found to have committed domestic violence[12]. However, the language in § 14-10-124 (4)(f), C.R.S. does not mention the DVOMB and does not provide any guidance to the court, court-ordered professionals, or family law practitioners regarding how any ordered domestic violence offender evaluation and treatment is to be achieved.[13]

While the statute provides that the court may review a report obtained from the Provider and use that to determine future court orders, the statute does not designate the qualifications needed for Providers or provide a framework for working with Providers, monitoring progress, ensuring accountability, or multidisciplinary collaboration. Court ordered treatment must also account for parenting deficits using validated interventions that are designed for domestic violence offenders, such as Caring Dads. Further, domestic relations and protection order/county courts are not equipped to oversee a process that includes these factors.

In order to address these concerns, the statute would need to include several changes:

I. All domestic violence evaluations and treatment ordered by these courts must be provided by DVOMB Approved Providers. Section 14-10-124(4)(f), C.R.S. should be amended to make this explicit.

II. Court orders for domestic violence offender evaluation and treatment must include specific documentation and information, such as detailed findings regarding the domestic violence, any evidence on which the court relied in making such findings, and any other information the court believes will assist the evaluator in assessing the offender's need for treatment and determining what type of treatment is needed (if any). Parties should not be ordered to complete an evaluation for purposes of making such a finding.

III. Victims of domestic violence should be advised by the court that they may be contacted by a DVOMB Approved Provider's agency or practice, of the purpose of the evaluation, of the role of the TVA, and that they may choose to participate in the evaluation and treatment process. Furthermore, victims should be encouraged to seek support from a confidential community-based domestic violence victim services agency and offered resources to locate one in their community.

IV. Victims should not be ordered to pay for offender evaluations, treatment or any other cost that is a result of the offender's abusive behavior. Such orders undermine the goals of treatment, burden victim finances, and place the responsibility for the offender's behavior on the wrong person.

V. The legislature must address the lack of infrastructure and lack of funding that allows offenders to avoid compliance with civil court orders and limits the consequences for failure to comply with findings of contempt of court and subsequent remedial or punitive measures.

[12] Domestic violence is not generally addressed in these cases unless the parties share children. As Colorado is a no-fault divorce state, issues such as property division, spousal maintenance, or other matters that courts address whether or not there are children involved, do not currently take a history of domestic violence into consideration.

[13] "When the court finds by a preponderance of the evidence that one of the parties has committed domestic violence, the court may order the party to submit to a domestic violence evaluation. If the court determines, based upon the results of the evaluation, that treatment is appropriate, the court may order the party to participate in domestic violence treatment. At any time, the court may require a subsequent evaluation to determine whether additional treatment is necessary. If the court awards parenting time to a party who has been ordered to participate in domestic violence treatment, the court may order the party to obtain a report from the treatment provider concerning the party's progress in treatment and addressing any ongoing safety concerns regarding the party's parenting time. The court may order the party who has committed domestic violence to pay the costs of the domestic violence evaluations and treatment."

3. Enhance and Strengthen Civil Protection Order Statutes

The civil protection order process, while quite different from the domestic relations process, is similar in the way the Best Interest Standard is used to address parental responsibilities. However, due to the abbreviated nature of that process[14], courts are less likely to order an evaluation and treatment while the case is ongoing. Additionally, where there are children involved, judicial officers frequently decline to address the care and control of children (short-term orders regarding parenting time and decision-making responsibility), requiring victims to file cases in domestic relations court instead. This undermines victim autonomy and reduces the effectiveness of the civil protection order in achieving victim and child safety. Because judicial officers assume that a victim seeking a civil protection order will not have further contact with the offender, they are most likely to order offender evaluation and treatment in cases where the parties share children. These concerns present additional challenges for updating the statute. Changes to the protection order statute that may assist in this are:

I. Provide the court with continuing jurisdiction to address compliance both during the pendency of a temporary protection order, which may be issued for up to one year, and throughout the existence of a permanent protection order, which is no less than two years and can remain in place indefinitely.

II. Require courts to issue care and control orders when requested by either party, and specify that the reference to §13-14-105(e)(IV), C.R.S. includes all possible remedies outlined in §124-10-124(4), C.R.S.

III. Address the same concerns outlined in subparagraph 2 above.

4. Direct the Colorado Department of Human Services to promulgate policy and procedural changes needed sustain ongoing case coordination with treatment

The Colorado Department of Human Services' Child Welfare Sub-Policy Advisory Committee should ensure that any orders for domestic violence offender evaluation and treatment comply with § 16-11-104(1) that mandates the Department of Human Services to refer to only DVOMB Approved Providers. It may be beneficial for there to be similar language in Title 19 that reflects this requirement for the Colorado Department of Human Services. Expanding the purview of the DVOMB and its mandates to civil cases would likely also reconcile the issues with using Treatment Victim Advocates in non-criminal cases. This group should also address the ability of county Departments of Human Services to use CORE dollars or other funding streams to fund Provider services.

5. Caseworker Involvement in Promoting Accountability and Engagement in Treatment Within Child Protection

The primary tool to orient caseworkers on addressing domestic violence is the Domestic Violence Practice Guide for Child Protective Services (Practice Guide). This tool, created by the State Division of Child Welfare, is intended to support case practice when domestic violence and child maltreatment concerns are co-occurring. However, it is reported that the Practice Guide is underutilized by case workers and predates the adoption of Differential Response. Underutilization of the Practice Guide is attributed to ongoing turnover with case workers, a lack of standardization in training expectations regarding this content, and limited opportunities for case workers and supervisors to be trained on the Practice Guide and its use. The impact of this underutilization is that Providers who want to engage with caseworkers frequently need to provide additional training and guidance as to the core dynamics of domestic violence, offender pathologies, and treatment approaches.

It would be helpful to Providers if initial and ongoing training on such content were provided to caseworkers, which could be achieved through standardized training on and application of the Practice Guide. The Practice Guide may assist caseworkers in understanding how to engage with offenders. Beyond this individual approach,

[14] The Civil Protection Order process, outlined in § 13-14-101, C.R.S., *et seq.*, begins with the issuance of a Temporary Civil Protection Order (TPO) and is followed by a hearing on the matter in no more than 14 days from the date the TPO is issued. While it is common for this process to take longer, rarely are both parties present before a judicial officer on more than two occasions.

finding ways for caseworkers to meaningfully partner with DVOMB providers and other MTT professionals will enhance the information available to dependency and neglect courts for case decision making and the likelihood of offender engagement. Caseworker actions and MTT oversight together would reduce the risk of future abusive behaviors and/or would flag the need for additional containment to achieve safety.

Any expansion or greater utilization of domestic violence offender treatment will necessitate more DVOMB Approved Providers. A shortfall of DVOMB Approved Providers is straining resources and the capacity to meet the existing needs of the criminal legal system. From FY20-21 to FY 21-22, the number of DVOMB Approved Providers decreased from 191 to 175. The cause for this decrease is likely attributable to a range of factors connected to the COVID-19 pandemic as well as interests to find other employment opportunities. While efforts are underway by the DVOMB to increase the availability and accessibility of Approved Providers, any measures to expand the scope of domestic violence offender treatment will need to address and consider the implications of the current workforce.

Section 3: Milestones and Achievements

Overview of FY2021-2022 Accomplishments

The following highlights some of the many additional achievements of the DVOMB in FY2021-2022:

- Managed six DVOMB committees
- Adjusted the way the DVOMB conducts business in response to the COVID-19 pandemic, while offering additional trainings and continuing all normal business in a virtual environment.
- Approved 80 applications for placement or continued placement on the DVOMB Approved Provider List during 2021.
- As of July 2022, there are 159 active and 16 not currently practicing treatment providers approved by the DVOMB in Colorado. Of those treatment providers, **130 are approved to work with female offenders** and **50 are approved to work with LGBTQ+ offenders.**
- Conducted 33 trainings virtually to over 1,417 attendees from across Colorado. These trainings covered a range of topics related to the treatment and supervision of individuals convicted of domestic violence offenses.
- Supported monthly Technical Assistance hours. On a monthly basis, DVOMB staff hosted two virtual, one-hour technical assistance sessions for approved providers. This allows staff to update providers on recent changes to the *Standards and Guidelines* as well as allowing providers to have questions answered.
- Contracted with Orange Circle Consulting to explore, study, and develop an outreach strategy to help reach the right people with the right tactics. This effort to create a strategy includes recruiting potential DVOMB Approved Providers with specific focus on diversity, equity, and inclusion.
- Implemented new statutory requirements and created systems for DVOMB Approved Provider to submit client data related to domestic violence offender services.

2021 Sunset Review and Reauthorization HB2022-1210

In FY2021-2022, the DVOMB underwent a Sunset Review by the Colorado Department of Regulatory Agencies (DORA). A sunset review is a periodic assessment of a state board or program to determine if that organization is meeting its statutory mandates and whether they should be continued by the state legislature. This comprehensive review of the DVOMB examined many different areas of the Board, its functions, and data.

The DORA Sunset Report of the DVOMB outlined three recommendations based on its analysis of the Board over the past five years since its last Sunset Review.

- Recommendation 1 - Continue the Domestic Violence Offender Management Board for 11 years, until 2033.
- Recommendation 2 - Require the DVOMB to review five percent of treatment providers each year.
- Recommendation 3 - Modernize the language related to criminal history record checks and fingerprinting.

This Sunset Report by DORA also included findings from a survey of approved treatment providers regarding customer service. There were 46 responses out of 175 Approved Providers. The service provided by the DVOMB was rated by 84.8% of respondents as very acceptable or acceptable. Moreover, the Board's communications (84.8%), listening to concerns (79.5%), timeliness (93.5%) and helpfulness (75.0%) received high scores overall.

The DORA Sunset Report of the DVOMB outlined three recommendations which were presented to the House Judiciary Committee. The legislature considered the recommendations from DORA and added new mandates to the DVOMB as part of the reauthorization bill House Bill 2022-1210 which continues the DVOMB until 2027. This bill specified that the DVOMB is now required to:

- Develop a data collection plan and require approved providers to begin data collection pursuant to the plan adopted by the Board no later than January 1st, 2023.
- On or before January 31st, 2023, and on or before each January 31st thereafter, the Board shall prepare and present a written report to the House of Representatives Judiciary Committee and the Senate Judiciary Committee, or their successor committees. The report must include:
    - The number of people who received domestic violence offender treatment in the preceding year, the number of those who successfully completed the treatment, and the number of those who did not complete treatment, and the number of those who reoffended and were removed from treatment;
    - The number of treatment providers who provided domestic violence offender treatment in the preceding year;
    - The number of treatment providers who applied to be placed on the list of approved treatment providers pursuant to (4)(a)(III)(C) of this section and the number of treatment providers place on the list;
    - The best practices for the treatment and management of domestic violence; and
    - Any other relevant information, including any Board recommendations for legislation to carry out the purpose and duties of the Board to protect the community.
- Perform compliance reviews on at least 10% of service providers every two years beginning no later than July 1st, 2023.

Sunset Reauthorization Response and Implementation of New Mandates

Shortly after the passage of the DVOMB reauthorization bill, the Board began developing plans on how to meet these new statutory mandates. A proposal was presented to the DVOMB during the May 2022 meeting regarding how to meet the new data collection requirement which was subsequently approved in September of 2022. This

data collection plan is provided in Appendix A and outlines the information requirements to be submitted by DVOMB Approved Providers. This plan offers two options for DVOMB Approved Providers to submit client-level data at discharge.

The first option to submit client level data is through the Provider Data Management System (PDMS) which is a governmental electronic record system maintained by the Colorado Department of Public Safety and administered by the DVOMB program staff. The other option available to DVOMB Approved Providers to submit data is through ReliaTrax which is an electronic health record system that is a privately owned and operated company. Approximately 78.6% of DVOMB Approved Providers subscribe to ReliaTrax as customers and enter treatment program data. For this reason, ReliaTrax and the DVOMB worked together to add the new data collection requirements to prevent DVOMB Approved Providers from having to enter data into both the PDMS and ReliaTrax systems unnecessarily. As of the date of this report, both the PDMS and ReliaTrax systems were primed and ready for data collection to begin on January 1st, 2023. DVOMB Approved Providers received training on the purpose of this data collection, the process for obtaining a research release from the clients, and how to enter the data. It is expected that the next annual legislative report will provide descriptive statistics on the client population, risk classifications and treatment needs, and the outcomes associated with offender treatment services on an aggregate level.

Regarding the new requirement to perform compliance reviews on at least 10% of DVOMB Approved Providers every two years beginning no later than July 1st, 2023, program staff have begun developing implementation plans on how to meet these new statutory mandates and the corresponding updates needed for the DVOMB Administrative Policies.

Efforts toward Diversity, Equity, and Inclusion

The DVOMB continued to prioritize discussions on diversity, equity, and inclusion (DEI). These efforts centered on learning more about implicit biases, cultural considerations, and how these issues can impact services under the *Standards and Guidelines*. The DVOMB incorporated new processes aimed at supporting DEI efforts in the composition and representation of those serving on the Board as well as at the committee level. Nomination forms added more inclusive questions that sought information which could help foster more diversity and lived experience for those appointments. These efforts were mirrored in the solicitation for abstracts to present at the annual conference. The inclusion of these questions required all abstracts to consider how DEI would be addressed in their presentation and produced three abstracts specifically addressing DEI. By offering these training opportunities, the goal of the DVOMB is to raise awareness of how issues of Diversity, Equity, and Inclusion impact the work of the DVOMB and affiliated stakeholders.

Further DEI work occurred at the committee level. In March of 2021, the DVOMB voted to create a Diversity, Equity, and Inclusion (DEI) Committee. The purpose of this committee is to explore and make recommendations regarding DVOMB *Standards and Guidelines* to enhance service delivery in areas related to cultural competency, implicit bias, trauma and broader social justice issues of racism and intersectionality. This committee was also empowered in its charter to identify possible training content areas for future DVOMB meetings and for Approved Providers. During the last year, the DEI Committee authored and recommended a new Guiding Principle[15] that speaks directly to the importance of service providers being aware and sensitive

[15] *GP 3.06 Cultural competencies and factors. The individualization of evaluations, assessment, and supervision requires particular attention to social and cultural factors. Recognition and respect of these factors to include ethnic, social, cultural, disability, race, creed, color, sex (including pregnancy, gender identity and sexual orientation), religion, national origin, citizenship, age, veteran status, or marital status backgrounds are essential when interacting with clients. These factors do not represent a comprehensive list or the challenges associated with intersectionality of these factors. A basic premise is to recognize the client's background, the Provider's own background, and how both affect the client-provider relationship. This premise extends to all professional members of the MTT and positive support persons and is essential in creating an equitable an equitable and inclusive environment. While the aforementioned factors may be an integral part of evaluation and treatment, said factors are never an excuse or justification for domestic violence of abusive behaviors.*

to the impact social and cultural factors can have with the therapeutic alliance. The DVOMB adopted this Guiding Principle into the *Standards and Guidelines* after public comments were reviewed and addressed.

Efforts to Recruit New Providers

The Office of Domestic Violence and Sex Offender Management (ODVSOM) provides support to the Domestic Violence Offender Management Board (DVOMB) and the Sex Offender Management Board (SOMB) that uphold the standards of practice for the assessment, evaluation, and treatment of individuals charged with domestic violence or sex offenses (DV/SO). To showcase the importance of an Approved Provider's role in delivering services in this field, the ODVSOM sought to develop an outreach plan to help reach the right people with the right tactics. The foundation of this work began with a communications goal of attracting new providers to this field of work. Together with marketing and research partner, Orange Circle Consulting (Orange Circle), ODVSOM completed formative research to better understand the existing audience and build audience profiles that will translate into messaging and outreach materials that will help attract qualified providers to this important work.

Orange Circle implemented a two-pronged approach for collecting audience data that included an online survey with individuals in pursuit of work, and currently working in, the field of therapy and counseling in Colorado and nationwide, as well as stakeholder focus groups and individual stakeholder interviews. The survey was intended to identify core values among individual who choose the field of therapy and counseling. It also sought to determine any familiarity with the Colorado *Standards and Guidelines* and identify what might motivate an individual to consider applying to become an approved provider.

All demographics data collected are outlined in the full report. A total of 309 people completed the survey. The priority was to obtain a representative sample based on location (Colorado resident preferred) age, gender, and race. The prioritization of Colorado respondents resulted in a much higher number of female respondents (79%) compared to male respondents (18%). There was a good representation of respondents from several ethnic groups including African American/Black (12.3%) and Hispanic/Latino (14.2%).

The following quantitative data results represent important content for consideration:

- Respondents indicated key influences for choosing work in the field of therapy including a desire to help people with their emotional and mental journey, followed closely by understanding the value and benefit of therapy, and to help clients address their concerns. The pay was rated the least influential for choosing a career in therapy.
- Over a fourth (27%) of respondents indicated they are familiar with Colorado Standards and Colorado respondents were more likely to be familiar than National. Around 5% of respondents indicated they are already approved providers.
- Over 87% of respondents indicated that "yes" or "maybe" they would consider becoming an approved provider.
    - There was a significant difference among Colorado and National respondents with National respondents being more willing to consider becoming an approved provider.
    - Students were more likely to say "maybe" to becoming an approved provider.
    - Those that were open to considering becoming an approved provider were more interested in learning about what it was like to work with DV/SO clients;

interested in learning the skills to work with DV/SO clients; and open to working with clients in the justice system.

- Those willing to consider becoming approved provider were influenced by helping provide victim safety through rehabilitation of offenders; adding knowledge about the intersection between psychology, law, and forensics; and helping at a community level to rehabilitate offenders.

- Those that were more familiar with the Colorado Standards were more likely to say "yes" to considering becoming an approved provider.

- Individuals who indicated that "yes" or "maybe" they would consider becoming an approved provider, listed the following aspects of the work that appealed to them: ability to learn new skills; opportunity to provide a community service and increase victim and public safety; and work in a social and community justice area.

- Those that indicated they would "maybe" or "not consider" becoming an approved provider felt that they would need more training to provide this type of therapy.

- There were significant differences among ethnic groups – Black, White, and Latino - in their beliefs around working with DV and SO clients.

- Overall, respondents were most influenced to work with court-ordered offenders by helping to provide victim safety through rehabilitation; adding knowledge about the intersection between psychology, law, and forensics; and helping at a community level to rehabilitate offenders.

Stakeholders were categorized as DV/SO Board Members, Supervisors, providers, and partners including community-based organizations (CBOs) and correctional/justice system representatives and participated in either a virtual individual interview or a virtual discussion group.

Research objectives included:

- Build an audience profile of current providers (e.g., skills; characteristics; and motivators).

- Discover how current providers learned about the DV/SO approval application and uncover the specific reasons why they moved forward with seeking approval.

- Describe key motivators that help attract (and retain) individuals/groups to providing services for specialized clientele.

- Identify barriers that may keep other providers from applying to be approved.

The following qualitative results represent important content for consideration:

- Established providers do not typically seek out work specific to DV/SO clients.

- Therapist motivators for working in DV/SO field are primarily intrinsic including: a desire to make a difference for both individuals and communities; a curiosity to learn more and problem solve, positive shifts in social justice and promoting community safety as well as working in forensics and investigation.

- Motivators that draw people to the field of counseling/therapy (seeing progress and changes in clients paired with making an impact on interrupting "generational violence") also apply to those that choose to work in the field of DV/SO treatment.

- Cutting edge, evidence-based practices are motivating factors for working in the field of DV/SO.

- Important characteristics for providers of DV/SO clients include: intrinsic curiosity of being a change agent; interest in helping people; being firm and consistent with clients; enjoy group therapy; interested in uncovering root causes; capability to set strong boundaries and hold high standards; excellent case management skills; and a willingness to track a lot of detailed information.

- Almost all participants described working with DV/SO clients as challenging (while some do believe it can also be a motivator) both mentally and emotionally.

- Many participants suggested that there was an additional element of professional liability and risk associated with being an approved provider due to the nature of the DV/SO clientele.

- Most participants agreed that the pay scale for DV providers did not match the amount of work necessary.

- The costs associated with finding and completing continuing education to maintain approval status was mentioned as a barrier to approval and renewal.

- Systemic challenges exist that may keep some providers from applying for approval.

- Internships and Mentors are critical tools for attracting and training new providers.

- Many participants reported the lack of ethnic and bilingual representation among DV/SO approved providers.

- Veteran participants recognized progress and proactive efforts that have been made by the board and are headed in the right direction with their refinements to attract new providers.

Conclusions based on the data include:

- For marketing and communication purposes, it may be necessary to consider targeting different types of audiences other than current therapists such as students pursuing degrees in the field of behavioral health. Furthermore, investing in the development of internships, and establishing more opportunities for mentorship programs can also help with recruitment of new approved providers.

- There are many intriguing and positive attributes of working with DV/SO clients that perfectly align with the values of why individuals go into the field of therapy and behavioral health services. Communications and targeted messaging should showcase the intrinsic benefits that motivate prospective providers and highlight the positive outcomes of being a part of the work.

- Although barriers to becoming involved in this field of work are not necessarily the focal point of messaging, transparency in outreach is important to help the audience gain confidence that some of those barriers are minimal or can be overcome.

- A concerted "positive public relations" outreach effort with internal audiences could help promote the proactive efforts ODVSOM is taking to address application renewal concerns.

- African American and Latino survey respondents indicated they are open to considering work with DV/SO clients but do still have some concerns about working with these types of clients. Targeted messaging to address this concern could offer ODVSOM the opportunity to capitalize on increasing the ethnic diversity of approved providers.

Implications for Communications Outreach

Defining the appropriate approach to reach the identified communications goal is dependent on specific variables including time, budget, and success measures. ODVSOM will work together with Orange Circle Consulting to pinpoint audiences, messaging, tactics, and addressing barriers to help define the right tactics for an outreach effort.

Applications for Placement on the DVOMB Approved Provider List

During fiscal year 2021-2022, the Application Review Committee of the DVOMB reviewed and approved a total of 73 applications for placement on the Approved Provider List which equates to an approval rate of 91 percent. There were seven pending applications and zero applications denied.

Table 1. DVOMB Count of Applications

Type	*Approved*	*Pending*	*Denied*	*Total*	*Percentage*
Trainee	28	1	0	29	91%
Associate Level[16]	20	1	0	21	95%
Full-Operating Level	2	0	0	2	100%
Domestic Violence Clinical Supervisor	1	0	0	1	100%
Move-Up	6	0	0	6	100%
Female Specific Offender Population	12	4	0	16	75%
LGBT+ Specific Offender Population	4	1	0	5	80%
Total	73	7	0	80	91%

Current Availability of Providers

As of July 2022, there are **159 active** and 16 inactive[17] treatment providers approved by the DOMB in Colorado. Treatment providers may choose to pursue an addition of services with their status. For example, a

[16] This was formally listed as Entry Level.
[17] If a Provider wishes to retain their listing status but is not providing any evaluation, treatment, coverage, peer consultation or clinical supervision services for domestic violence offenders, the Provider may request to be placed on Not Currently Practicing Status. During this time, a Provider will retain their status on the Provider List, but shall not provide any domestic

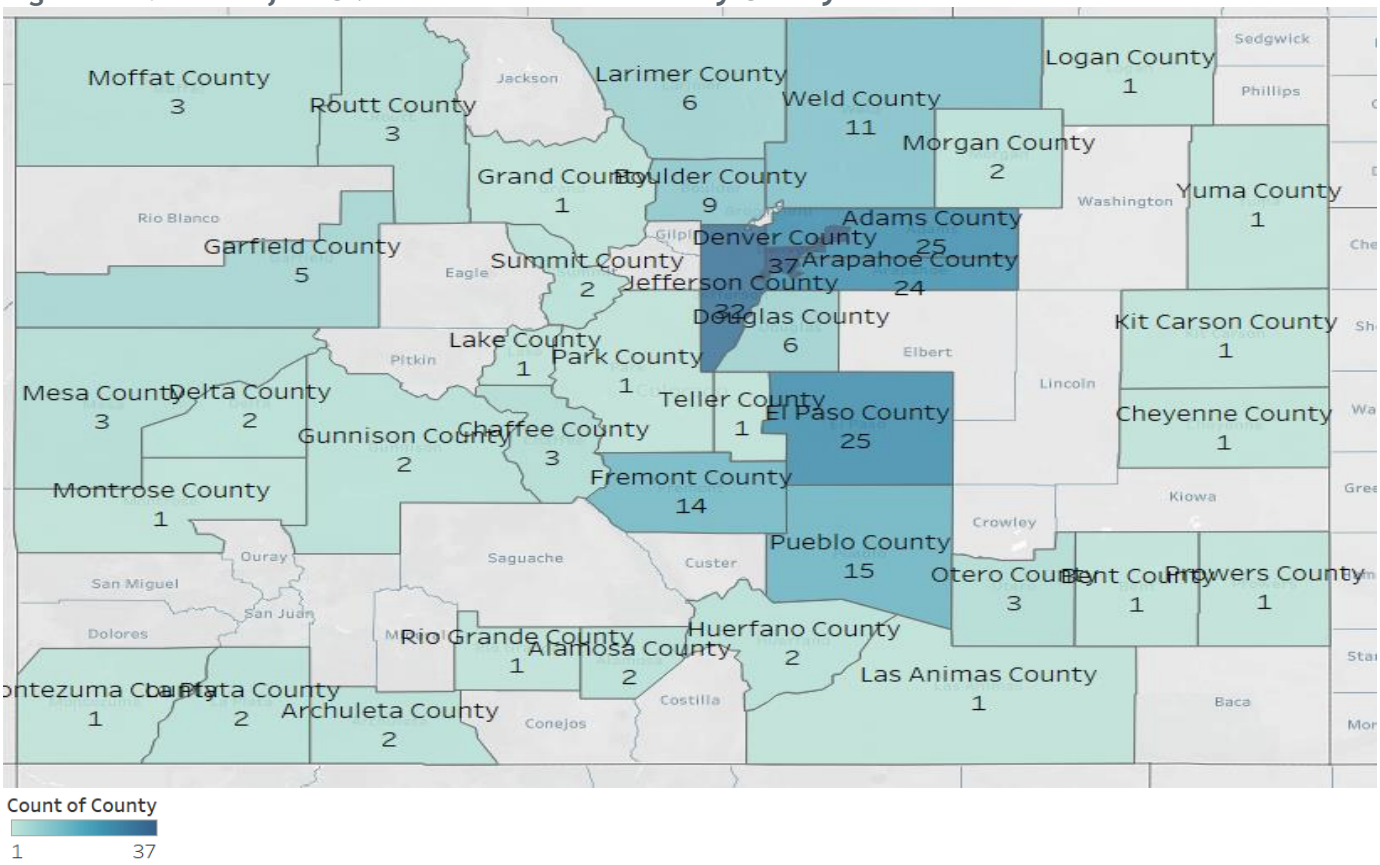
treatment provider may also be approved to work with a Specific Offending Population: female offenders and LGBTQ+ offenders. Of those treatment providers, **130 are approved to work with female offenders** and **50 are approved to work with LGBTQ+ offenders**. Table 2 provides the current statistics on the availability of service providers approved to operate in Colorado.

Table 2. Number of Approved Service Providers in Colorado, FY2021-2022

Level	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FY21-22
Provisional	3	1	4	3	2	2
Associate	24	26	26	40	35	36
Full Operating	106	103	81	88	94	90
Clinical Supervisor	41	53	45	35	37	31
Subtotal	174	183	156	166	168	159
Not Currently Practicing	19	21	23	21	23	16
Grand Total	**193**	**204**	**179**	**187**	**191**	**175**

On average, providers operated in three different counties. In total, the DVOMB has approved providers located in all 22 judicial districts in the state, as depicted in Figure 1.

Figure 1. Number of DVOMB Treatment Providers by County



violence offender services including treatment, evaluations, coverage, and peer consultation or clinical supervision. The Not Currently Practicing status may be requested by the Provider at any time.

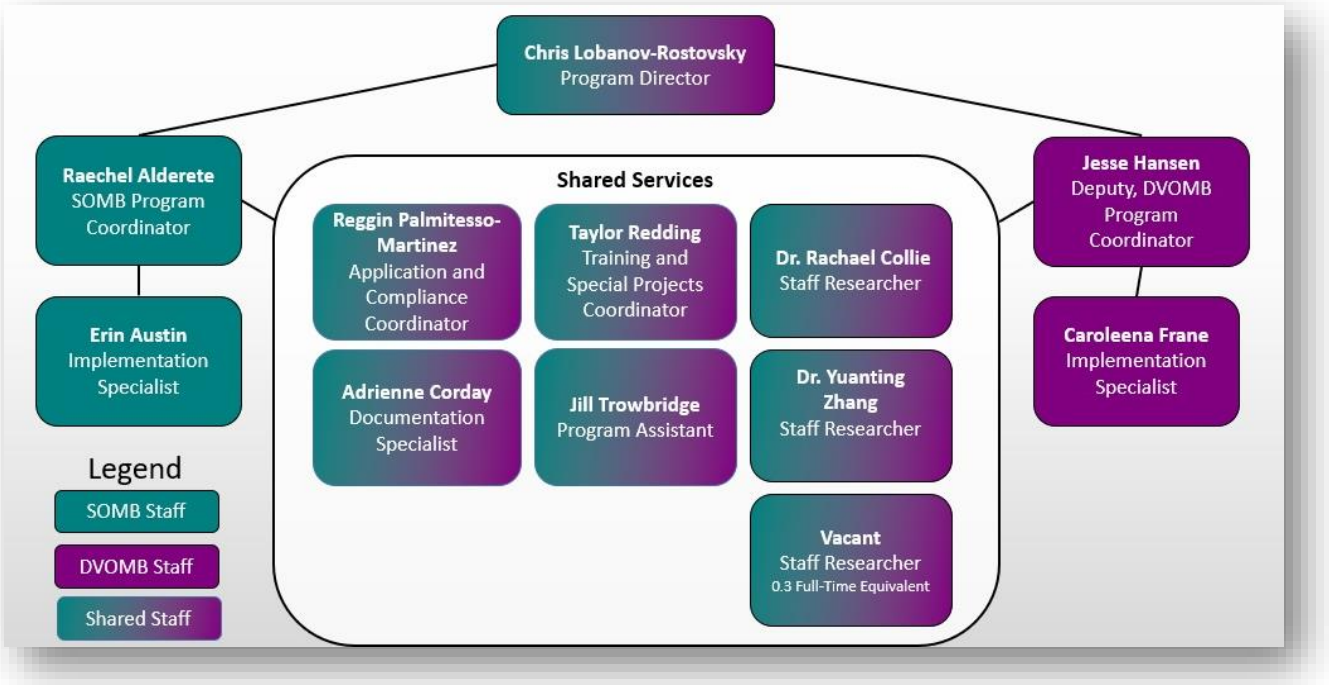
Reorganization for the Office of Domestic Violence and Sex Offender Management

Program staff supporting the Domestic Violence Offender Management Board (DVOMB) is situated in the Office of Domestic Violence and Sex Offender Management (ODVSOM) which also supports the Sex Offender Management Board (SOMB). In 2016, the program staff supporting the Sex Offender Management Board (SOMB) and the Domestic Violence Offender Management Board (DVOMB) were combined into one office. While the SOMB and DVOMB are defined separately by law, both Boards are structured very similarly and possess similar guiding principles and mandates. The duties for some of the program staff lacked specialization, leading to staff duplicating administrative processes unnecessarily. Other program staff shared duties that were dispersed across technical and policy areas. This created opportunities for errors and inconsistent processes.

The convergence of mandates and functions, along with the inefficiencies of program staff responsibilities pointed to the need for a new and more responsive organizational framework. Since the inception of the DVOMB in 2000 there has been an increase in the number of DVOMB Approved Providers and the stakeholders who work with domestic violence offenders. The complexity for how the DVOMB *Standards and Guidelines* are interpreted and applied has also changed overtime. In addition to the Board's current mandates, the expectations of the DVOMB is expanding to include more efforts regarding program implementation and compliance monitoring of DVOMB Approved Providers.

To address these new challenges, the ODVSOM conducted a comprehensive review of its organizational structure and explored options to integrate staff roles in a more purposeful and systematic way. The result of this process revamped staff responsibilities and produced a new staffing configuration that maximized current resources and positions to meet the current needs of stakeholders. The new staffing configuration is shown in the figure below and is referred to as the Shared Services Model.

Figure 2. The ODVSOM Shared Services Model and Organizational Chart



Within the Shared Services Model, all of the administrative, planning, and logistical resources are centralized to support both the DVOMB and SOMB. These positions are now specialized and eliminate the areas where duplicative processes occurred. Attached to the Shared Service Model are two wings on either side to distinguish the primary staff designated to provide direct support and leadership to the SOMB and the DVOMB respectively.

These wings comprise of a program coordinator in charge of strategy and operations as well as an implementation specialist. The implementation specialist is a new role that focuses on capacity building and change management for matters pertaining to the *Standards and Guidelines* in communities across the state. These positions are a direct resource that can offer training and technical assistance more readily.

Continued Utilization of Online Mediums for Board Operations

The COVID-19 Pandemic was an incredibly impactful event throughout the course of 2020 and continued in 2021. The DVOMB made significant changes to the way that business was conducted for the DVOMB, the DVOMB's staff, and the service providers across the state. In an effort to ensure that the DVOMB's support and access was not disrupted by the pandemic, the DVOMB migrated all of its in-person trainings, committee meetings, and Board meetings to online formats. Additionally, the Board approved new requirements for the use of teletherapy within domestic violence offender evaluation and treatment. These requirements are listed in Appendix I of the DVOMB *Standards and Guidelines* which formerly prohibited the use of teletherapy. The DVOMB will evaluate and continue to assess how and in what ways teletherapy can be used as a modality for offender treatment.

Policy Updates

Committees

The majority of the work conducted by the DVOMB occurs at the committee level. Within these committees, a variety of policy and implementation related work is proposed, discussed, and reviewed by relevant stakeholders. These committees then make proposals for the DVOMB to consider. The DVOMB staffed six active committees and workgroups during the course of fiscal year 2021-2022, which were open to all stakeholders in order to work on statutorily mandated duties. These committees included the following:

1. Executive Committee
2. Application Review Committee
3. Diversity, Equity, and Inclusion Committee
4. Standards Revisions Committee
5. Victim Advocacy Committee
6. Training Committee (in Collaboration with the Sex Offender Management Board)

All of these committees have been and continue to be engaged in studying advancements in the field of domestic violence offender management, recommending changes to the *Standards and Guidelines* as supported by research, and suggesting methods for educating practitioners and the public to implement effective offender management strategies.

Ongoing implementation

Ongoing implementation refers to the dissemination of information from the DVOMB to approved service providers. The main components of ongoing implementation include training professionals, implementing policies with fidelity, and offering research/program evaluation support activities. This is a process that DVOMB is consistently working on, and mechanisms have been put in place to ensure that there is continuous progress in this area. There are consistent training programs that are offered by the DVOMB to provide updated information and guidance to DVOMB Approved Providers. The DVOMB hosts bimonthly technical assistance hours for providers

along with consistent online and in person trainings on a wide variety of topics pertinent to the field. The DVOMB also retains lines of communication for providers and stakeholders through the use of email lists for communication and a quarterly newsletter.

Training

In fiscal year 2021-2022, the DVOMB provided 33 trainings virtually to over 1,417 attendees from across Colorado. These trainings covered a range of topics related to the treatment and supervision of individuals convicted or adjudicated for sexual offenses such as:

- *DV100* - Introduction to the DVOMB and the Standards
- *DV101 – Domestic Violence Risk and Needs Assessment Training*
- DV102 – Offender Evaluations Training
- DV103 – Offender Treatment Training
- Treatment Plans Training
- Tackling Heteronormativity and Whitewashing in SO/DV Treatment: Holding space for LGBTQIA and BIPOC populations
- Incel Subculture - Preventing Targeted Violence
- Using Risk, Needs, and Responsivity for Effective Treatment Planning
- Domestic Violence and Human Trafficking Training
- Hidden in Plain Sight: The Connection Between Domestic Violence, Brain Injury, Substance Use and Addiction

Section 4: Future Goals and Directions

The mission of the DVOMB as written in its enabling statute is to have continuing focus on public safety. To carry out this mission for communities across the state, the DVOMB strives toward the successful rehabilitation of offenders through effective treatment and management strategies while balancing the welfare of individuals harmed by domestic violence, their families and the public at large. The DVOMB recognizes that over the past 20 years, much of the knowledge and information on domestic violence has evolved. Since the creation of the DVOMB, the *Standards and Guidelines* for the assessment and treatment of domestic violence offenders has been a 'work in progress.' Thus, periodic revisions to improve the *Standards and Guidelines* remains a key strategic priority for the DVOMB through its process of adopting new research and evidence-based practices as they emerge from the literature and the field. The DVOMB will continue to recognize the key role that the RNR model plays in the successful rehabilitation and management of individuals who commit domestic violence offenses.

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Appendices

Appendix A. DVOMB Data Collection Plan

Case Information

1. Has the client voluntarily signed the required consent form to participate in this data collection?

◯	**Yes**	◯	**No**

2. If yes, what is the client's Case Designation Number:

Year: Case Number: County:

3. From where was the client referred? (Select all that Apply)

◯	Probation	◯	County DHS/DYS
◯	Private Probation	◯	Court
◯	Community Corrections	◯	Private Attorneys
◯	Parole	◯	Self-referred
◯	Diversion	◯	Other (Open Text Box)

4. For the current domestic violence offender treatment order, was this client on unsupervised probation at any point in time?

◯	**Yes**	◯	**No**

Demographic Information of the Client

5. Gender

◯	Male
◯	Female
◯	Intersex
◯	Transgender Female
◯	Transgender Male
◯	Non-Binary
◯	Two-Spirit
◯	Not Listed (Open Text Box)

6. Sexual Orientation

◯	**Heterosexual**	◯	**Pansexual**
◯	Gay	◯	Asexual
◯	Lesbian	◯	Questioning
◯	Bisexual	◯	Self-identify as (Open Text Box)

7. Race/Ethnicity (Select All that Apply)

◯	White	◯	Latino
◯	Black/African American	◯	Asian
◯	Asian or Pacific Islander	◯	Native Hawaiian
◯	Hispanic	◯	Native American
◯	Not listed here (Open Text Box)		

8. Hispanic Origin

◯	Cuban	◯	Latino
◯	Mexican	◯	Puerto Rican
◯	Not Hispanic Origin	◯	Other Specific Hispanic
◯	Not listed here (Open Text Box)		

9. What cultural background does the client self-identify with? _____

10. Age at the time of the offense: _____

11. Relationship to the identified victim at the time of the offense: (Select all that Apply)

◯	Dating
◯	In an exclusive relationship
◯	Common Law
◯	Married
◯	Separated
◯	Divorced
◯	Widowed
◯	Not listed here (Open Text Box)

12. What is the offender's primary language?

◯	**English**
◯	Spanish
◯	Russian
◯	Mandarin
◯	Not listed here (Open Text Box)

13. Highest education at the time of the offense?

◯	Less than high school degree
◯	High school degree or equivalent (e.g., GED)
◯	Vocational schooling
◯	Some college but no degree
◯	Associate degree
◯	Bachelor degree
◯	Graduate degree
◯	Doctoral degree and above

14. What is the crime of conviction for the current treatment? (Optional)

	Formal Charges		**Convictions**		
Crimes	**Felony**	**Misdemeanor**	**Felony**	**Misdemeanor**	**Petty Offense**
Domestic Violence Enhancer	◯	◯	◯	◯	◯
Assault	◯	◯	◯	◯	◯
Strangulation	◯	◯	◯	◯	◯
Menacing with a weapon	◯	◯	◯	◯	◯
Stalking	◯	◯	◯	◯	◯
Harassment	◯	◯	◯	◯	◯
Attempted murder	◯	◯	◯	◯	◯
Burglary	◯	◯	◯	◯	◯
Criminal Trespass	◯	◯	◯	◯	◯
Criminal Mischief	◯	◯	◯	◯	◯
Other:	{Text box}	{Text box}	{Text box}	{Text box}	{Text box}

15. Were the protection orders modified prior to the start of domestic violence offender treatment?

◯	**Yes**	◯	**No**	◯	**Unknown**

Post-Sentence Offender Evaluation Information

16. Was the evaluation completed within 30 days? If no, please explain why. (Optional)

◯	Yes	◯	No

If no, please explain:

17. What documents were used during the evaluation process?

◯	Law Enforcement Summary Report	◯	Substance Abuse Evaluation
◯	Criminal History	◯	Previous domestic violence offender evaluations
◯	Mental Health Records	◯	Victim Statement
◯	Other (Open Text Box)		

18. Please indicate what risk factors on the DVRNA were present at time of the offender evaluation being completed?

At Time of Evaluation	**At Time of Discharge** (Optional)	**Domain**	**Title**
◯	◯	Domain A:	PRIOR DOMESTIC VIOLENCE RELATED INCIDENTS
◯	◯	A1:	Prior domestic violence conviction
◯	◯	A2:	Violation of an order of protection
◯	◯	A3:	Past or present civil domestic violence related protection orders against offender
◯	◯	A4:	Prior arrests for domestic violence
◯	◯	A5:	Prior domestic violence incidents not reported to criminal justice system
◯	◯	Domain B:	DRUG OR ALCOHOL ABUSE
◯	◯	B1:	Substance abuse/dependence within the previous 12 months

◯	◯	B2:	History of substance abuse treatment within the previous 12 months, or two or more prior drug and alcohol treatment episodes during adult lifetime
◯	◯	B3:	Offender uses illegal drugs or illegal use of drugs
◯	◯	Domain C:	MENTAL HEALTH ISSUES
◯	◯	C1:	Existing Axis I or II diagnosis excluding V codes
◯	◯	C2:	Personality disorder with anger, impulsivity, or behavior instability (SARA, 2008)
◯	◯	C3:	Severe psychopathology
◯	◯	C4:	Recent psychotic and/or manic symptoms (SARA, 2008)
◯	◯	C5:	Psychological/psychiatric condition currently unmanaged
◯	◯	C6:	Non-compliance with prescribed medications and mental health treatment
◯	◯	C7:	An offender exhibits symptoms that indicate the need for mental health evaluation
◯	◯	Domain D:	SUICIDAL/HOMICIDAL
◯	◯	D1:	Serious homicidal or suicidal ideation/intent within the past year
◯	◯	D2:	Ideation within past 12 months
◯	◯	D3:	Credible threats of death within past 12 months
◯	◯	D4:	Victim reports offender has made threats of harming/killing her
◯	◯	Domain E:	USE AND/OR THREATENED USE OF WEAPONS IN CURRENT OR PAST OFFENSE OR ACCESS TO FIREARMS
◯	◯	E1:	Gun in the home in violation of a civil or criminal court order
◯	◯	E2:	Use and/or threatened use of weapons in current or past offense
◯	◯	E3:	Access to firearms
◯	◯	Domain F:	CRIMINAL HISTORY – NONDOMESTIC VIOLENCE (BOTH REPORTED AND UNREPORTED TO CRIMINAL JUSTICE SYSTEM)
◯	◯	F1:	Offender was on community supervision at the time of the offense
◯	◯	F2:	Offender has a prior arrest for assault, harassment, or menacing
◯	◯	F3:	Prior nondomestic violence convictions at any time during offender's adult life
◯	◯	F4:	Past violation(s) of conditional release or community supervisions
◯	◯	F5:	Past assault of strangers, or acquaintances
◯	◯	F6:	Animal cruelty/abuse
◯	◯	Domain G:	OBSESSION WITH THE VICTIM (CURRENT VICTIM OR CURRENT PARTNER ONLY)
◯	◯	G1:	Stalking or monitoring

◯	◯	G2:	Obsessive jealousy with the potential for violence, violently and constantly jealous, or morbid jealousy
◯	◯	Domain H:	SAFETY CONCERNS
◯	◯	H1:	Victim perception of lack of safety/victim concerned for safety
◯	◯	H2:	Victim (female victim in heterosexual relationship) believes offender is capable of killing her
◯	◯	H3:	Offender controls most of victim's daily activities
◯	◯	H4:	Offender tried to strangle ("choke") victim
◯	◯	H5:	Physical violence is increasing in severity
◯	◯	H6:	Victim forced to have sex when not wanted
◯	◯	H7:	Victim was pregnant at the time of the offense and offender knew this
◯	◯	H8:	Victim is pregnant and offender has previously abused her during pregnancy
◯	◯	Domain I:	VIOLENCE AND/OR THREATENED VIOLENCE TOWARD FAMILY MEMBERS INCLUDING CHILD ABUSE
◯	◯	I1:	Current or past social services case as an adult where the offender was party to the action
◯	◯	I2:	Past assault of family members
◯	◯	I3:	Children were present during the offense (in the vicinity)
◯	◯	Domain J:	ATTITUDES THAT SUPPORT OR CONDONE SPOUSAL ASSAULT
◯	◯	J1:	Explicitly endorses attitudes that support or condone intimate partner assault
◯	◯	J2:	Appears to implicitly endorse attitudes that support or condone intimate partner assault
◯	◯	Domain K:	PRIOR COMPLETED OR NON-COMPLETED DOMESTIC VIOLENCE TREATMENT
◯	◯	Domain L:	VICTIM SEPARATED FROM OFFENDER WITHIN THE PREVIOUS SIX (6) MONTHS
◯	◯	Domain M:	UNEMPLOYED
◯	◯	Domain N:	INVOLVEMENT WITH PEOPLE WHO HAVE PRO-CRIMINAL INFLUENCE
◯	◯	N1:	Some criminal acquaintances
◯	◯	N2:	Some criminal friends

19. What secondary domestic violence risk assessment instrument was used at time of the offender evaluation?

	Instrument	Response Scores
◯	SARA III	Low, Moderate, High
◯	DVI	Low (0-39%), Medium (40-69%), Problem (70-89%), Extreme (90-100%)
◯	ODARA	1 (score 0), 2 (score 1), 3 (score 2), 4 (score (3), 5 (score 4), 6 (score 5-6), 7 (score 7-13)
◯	Danger Assessment	Variable danger (0-7), Increased danger (9-13), Severe danger (14-17), Extreme Danger (18+)
◯	B-SAFER	Low, Moderate, High, Other
◯	Other Risk	(Open Text Box)

20. What overall level of treatment was recommended and placed, the second contact recommendation, and date the post-sentence evaluation was completed?

Item	Response
DVRNA Level Recommended	Level A, Level B, Level C, N/A For N/A, was domestic violence offender treatment not recommended? Yes, No If no, please provide an explanation. (Open Text Box)
Treatment Level Placed	Level A, Level B, Level C, N/A For N/A, was the client placed in domestic violence offender treatment? Yes, No If no, please provide an explanation. (Open Text Box)
Override	Yes, No If yes, please describe the reason for the override.
Second Contact Recommendation (Select all that Apply)	Mental Health, Substance Abuse, MRT, EMDR, Other, N/A Please specify the other second contact recommendation: (Open Text Box)

Treatment Information

21. Date domestic violence offender treatment started: ☐

Note: In circumstances where a client discharges from domestic violence offender treatment and is subject to a new court order, this field should reflect the date in which the client starts the most current treatment episode.

22. Date domestic violence offender treatment ended: ☐

23. What modalities of treatment were used with this client? (Select All that Apply)

	Modalities
◯	Group
◯	Individual
◯	Group (Teletherapy)
◯	Individual (Teletherapy)
◯	Teletherapy for Medical or Weather-Related Emergencies Only
◯	Not listed here

What methods did you use to address the client's responsivity to treatment?

24. Was the therapeutic alliance assessed and adjusted?

◯	Yes	◯	No

25. How was the client's responsivity assessed?

◯	Client Feedback
◯	Collateral contact
◯	Topic of treatment session
◯	N/A
◯	Not listed here (Open text box)

26. What barriers (responsivity factors) to progress were identified during the course of treatment? (Select all that apply)

◯	Adjunct treatment needs	◯	Housing
◯	Client Factors	◯	Lack of engagement with the community
◯	Community Limitations	◯	Lack of social supports
◯	Cultural needs	◯	Specific Resources
◯	Employment	◯	Terms of Supervision
◯	Finances	◯	Transportation
◯	Other (Open text box)	◯	N/A

27. How was treatment adjusted to address the client's responsivity factors? Check all that apply.

◯	Adjunct treatment needs	◯	Housing
◯	Client Factors	◯	Lack of engagement with the community
◯	Community Limitations	◯	Lack of social supports
◯	Cultural needs	◯	Specific Resources
◯	Employment	◯	Terms of Supervision
◯	Finances	◯	Transportation
◯	Other (Open text box)	◯	N/A

28. Did you utilize any offender evaluations from the previous treatment provider in your current treatment plan?

◯	Did not receive it.
◯	Received and used it.
◯	Received but did not use it.
◯	N/A

29. Did you utilize the discharge summary from the previous treatment provider in your current treatment plan?

◯	Did not receive it.
◯	Received and used it.
◯	Received but did not use it.
◯	N/A

30. How many absences from domestic violence offender treatment did the client have?

Total absences during the length of treatment:	{Number}

31. Core Competencies

Core Competency	**Demonstrated**	**Not Demonstrated**
Offender commits to elimination of abusive behavior	◯	◯
Offender demonstrates change by working on the comprehensive Personal Change Plan	◯	◯
Offender completes a comprehensive Personal Change Plan	◯	◯
Offender development of empathy	◯	◯

Offender accepts full responsibility for the offense and abusive history	◯	◯
Offender identifies and progressively reduces pattern of power and control behaviors, beliefs, and attitudes of entitlement	◯	◯
Offender Accountability (Refer to 4.0 Appendix)	◯	◯
Offender acceptance that one's behavior has, and should have, consequences	◯	◯
Offender participation and cooperation in treatment	◯	◯
Offender ability to define types of domestic violence	◯	◯
Offender understanding, identification, and management of one's personal pattern of violence	◯	◯
Offender understanding of intergenerational effects of violence	◯	◯
Offender understanding and use of appropriate communication skills	◯	◯
Offender understanding and use of "time-outs"	◯	◯
Offender recognition of financial abuse and management of financial responsibility	◯	◯
Offender eliminates all forms of violence and abuse	◯	◯
Offender prohibited from purchasing, possessing, or using firearms or ammunition	◯	◯
Offender identification and challenge of cognitive distortions that plays a role in the offender's violence	◯	◯

32. If known, did the victim opt in for Treatment Victim Advocacy services?

◯	Yes	◯	No

If no, please indicate why the victim may not have opted in (if known). (Open text box)

33. Type of discharge

◯	**Completed Discharge**	◯	**Unsuccessful Discharge**	◯	**Administrative**
Discharge Reason		Discharge Reason		Discharge Reason	
Optional		Optional		Optional	
◯	Client Met Core Competencies	◯	Never Attended/Failed to Begin Program	◯	Transferred to Another Agency
		◯	Dropped out of Program/Abandoned Treatment	◯	Transferred Out-of-State
		◯	Non-Compliance with Monitored Sobriety/Drug Alcohol Use	◯	Moved to Different Part of State
		◯	Probation terminated, request to extend unsuccessful	◯	Death
		◯	Violation of Treatment Plan/Contract	◯	Other {Text box}
		◯	Unsuccessful in Progressing with Core Competencies		
		◯	Violation of terms and conditions of supervision		
		◯	Unable to meet financial responsibilities		
		◯	Excessive Absences		
		◯	New domestic violence related offense		
		◯	New non-domestic violence related offense		
		◯	Other {Text box}		

34. Was there a level change through the course of treatment?

◯	Increased	◯	Decreased	◯	No Change

Appendix B. Best Practice Guidelines for Working with Youth Who Engage in Relationship Abuse

Printable Resources

English

Best Practice Guidelines for Working with Youth Who Engage in Relationship Abuse - May 2021

Summary - Best Practice Guidelines for Working with Youth Who Engage in Relationship Abuse

FAQs

Español

Directrices de Mejores Prácticas para Trabajar con Jóvenes Quienes Participan en Relaciones Abusivas

Guía de Mejores Prácticas para el Tratamiento de Jóvenes involucrados en Relaciones de Abuso - Resumen

Preguntas frecuentes

Appendix C. Referrals for Offender Treatment Evaluations and Services in Domestic Violence Civil Cases Without Criminal Findings: Challenges and Recommendations

Introduction

This white paper provides contextual information and highlights policy issues concerning individuals who are referred to a Domestic Violence Offender Management Board (DVOMB) Approved Provider as a result of a civil court order AND who do not have any pending criminal charges nor a recent criminal conviction related to domestic violence. This issue came before the DVOMB at the request of professionals operating in the civil legal arena, who were finding it difficult to refer individuals who did not have a prior criminal conviction for evaluation and treatment services. If an offender has both a civil and criminal order requiring a domestic violence offender evaluation and treatment as recommended, the DVOMB *Standards and Guidelines* apply and shall be followed. However, in instances where there is not a criminal filing or sentence leading to the referral for services, the absence of overt authority and established practice guidance leaves DVOMB Approved Providers uncertain of how to appropriately and safely engage with this population. This white paper presents background information, key considerations and identified concerns, and a discussion of the statutory authority for DVOMB Approved Providers (hereafter as Providers) to engage with individuals referred for treatment through civil cases. Recommendations to address identified areas of concern are included.

For the purposes of this white paper, the civil legal system includes domestic relations cases (dissolution of marriage/divorce and allocation of parental responsibilities/child custody), civil protection order cases, and dependency and neglect cases initiated by local departments of human services' child welfare divisions. These cases often involve allegations and findings of domestic violence. The Best Interest of the Child Standard § 14- 10-124, C.R.S. used in both domestic relations and civil protection order cases, specifically states that the court may refer a person found to have committed domestic violence for an offender evaluation and/or treatment. However, the statute does not mention the DVOMB and is silent as to how the referral process is to occur.

The DVOMB *Standards and Guidelines* are specific to individuals who are convicted and sentenced according to § 16-11.8-103(4)(a)(II), C.R.S. for crimes which meet the statutory definition of domestic violence[18]. For cases that fall outside the purview of the DVOMB, Providers are not bound by the *Standards and Guidelines* and may exercise discretion regarding if and how to evaluate and treat individuals, including individuals referred solely by civil court order. It is important to note that domestic violence offender services are not intended or appropriate for victims of domestic violence. There are significant differences between criminal

[18] C.R.S. 18-6-800.3(1): "Domestic violence" means an act or threatened act of violence upon a person with whom the actor is or has been involved in an intimate relationship. "Domestic violence" also includes any other crime against a person, or against property, including an animal, or any municipal ordinance violation against a person, or against property, including an animal, when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

and civil courts in how they may address the domestic violence allegations. These differences include variance in how domestic violence is defined, the burden of proof required for a finding of domestic violence, how institutional systems approach and respond to domestic violence cases, and the resources available for oversight. Specifically, DVOMB stakeholders have raised concerns about the civil legal system's lack of infrastructure for accountability and multi-disciplinary oversight of offenders, whereas such elements do exist within the criminal legal system and are identified as central to appropriate intervention. As a result, DVOMB Approved Providers have expressed reservations about working with offenders who fall outside of the *Standards and Guidelines*.

Addressing domestic violence is important not only for the safety of the victim, but also for the protection of any children involved within that family system. The negative intergenerational impact of domestic violence on children has been demonstrated unequivocally in the literature (Ireland and Smith 2009; McDonald et al. 2006). For children who see a caregiver harmed, who may be present for and injured during violent incidents, and who may be subject to developmentally inappropriate expectations by an offender parent, these experiences create toxic stress. Children are considered a vulnerable population for which experiencing domestic violence during formative and developmental years can increase risk factors associated with important developmental domains (family-of- origin disadvantage, parent stressors, adolescent stressors, antisocial behaviors, family violence, delinquent peers, early intimate relationships, educational experiences).[19]

Terms to be used in this paper

When discussing domestic violence, there are a number of varying terms used in different professional contexts to describe the behaviors of concern, the people using the concerning behaviors, and the people who are the targets of the concerning behavior. For the purposes of clarity and consistency the various terms are listed below, and the particular language that will be used within this document is identified. The behaviors of concern when discussing domestic violence are variously referred to in different contexts as domestic violence, domestic abuse, abusive behavior, battering, coercive control, interpersonal violence and intimate partner violence. Descriptively, the behaviors of concern may include using intimidation, isolation, emotional abuse, threats, financial abuse, physical and sexual violence, and other forms of violence against a current or former intimate partner. Within this document these behaviors will be referred to as domestic violence.

A person engaging in domestic violence is variously referred to in different contexts as a domestic violence offender, the person using abuse, perpetrator, offender, abuser, individual who commits domestic violence offenses, batterer, and offending party. The multi-dimensional components of an individual are respected and are not intended to be minimized in selecting a single, potentially pejorative,

[19] A 2015 study by Smith et al. found that the cumulative effect of risk factors equated to a person being 1.25 times more likely to commit IPV in emerging adulthood and 1.18 times more likely to commit IPV in adulthood, regardless of gender. The negative short- and long-term impacts on children underscore the importance of meaningful intervention with offenders. Treatment for domestic violence offenders requires specialization when brought to the attention of caseworks, judicial officers, and attorneys.

term for referring to people using domestic violence. Within this document the terms “domestic violence offender” and “offender” will be used to refer to these individuals.

A person who is the target of domestic violence is variously referred to in different contexts as the person experiencing harm, the person experiencing abuse, the person surviving abuse, domestic violence survivor, survivor, victim, victim-parent and adult victim. The multi- dimensional components of an individual are respected and are not intended to be minimized in selecting a single, potentially pejorative, term for referring to people who are the targets of domestic violence. Within this document the term “domestic violence victim” and “victim” will be used to refer to these individuals.

Background and Scope

For a variety of reasons, domestic violence may be addressed in civil courts without concurrently being addressed in criminal courts. Victims seeking remedy following domestic violence frequently are not engaged with law enforcement or criminal legal systems and instead are solely involved in the civil legal system. Civil legal involvement may be via civil protection orders or domestic relations matters, where the abuse may be addressed. It is worthwhile to note that not all criminal acts are charged as domestic violence even when the behaviors fit a broader domestic violence definition. Frequently, victims of domestic violence are seeking help within civil systems in circumstances where the offender has not been criminally charged for abusive acts.

There are three types of civil cases where domestic violence may be identified and offenders referred to a Provider for services: civil protection orders; domestic relations cases; and dependency and neglect cases[20]. These three case types differ significantly in how they come before the court and in the focus of the court’s interventions. However, the one thing they have in common is that there is often no “charge” or “conviction” for acts of domestic violence.

Civil protection order cases are brought by a victim of domestic violence seeking a court order prohibiting the offender from contacting or being physically near the victim. These cases may also include temporary orders regarding child custody. The focus of these cases is safety and the protection of the victim (and children) from continued acts of abuse by the offender. The offender may be ordered to complete an offender evaluation and treatment as a result of a court’s order in these cases.

Domestic relations cases include dissolution of marriage (divorce) and allocation of parental responsibilities (child custody). The Best Interest of the Child Standard § 14-10-124(1.3)(a), C.R.S., provides a definition of domestic violence to be applied in these cases. The goal of these cases, where children are involved, is to ensure the best interests of the children are prioritized when determining parenting time and decision-making responsibility. Courts often focus on the ability of the parents to work together for the children’s best interest, and are supposed to consider the adult victim’s and the children’s safety, along with the impact of

[20] Pursuant to § 14-10-124(4)(IV)(f), C.R.S., if a finding of domestic violence is made, the offending party (hereafter client) may be ordered to participate in a domestic violence offender evaluation and treatment as recommended.

domestic violence, when doing so. An order for an offender evaluation and treatment may be issued at any time while a case is moving forward, and may be done "post-decree," meaning after the initial custody orders are issued, if there is a filing seeking to change the current parenting orders.

Dependency and neglect cases are brought by a county Department of Human Services in situations where a child has been abused or neglected and where court ordered service plans are seen as necessary to establish safety for the child. In these cases, the parent(s) or caregiver(s) of the child are the parties who are considered responsible for the harm to the child. The goal in these cases is to remedy the factors that are creating risk to the child, through the successful completion of a treatment plan by each parent. Referral for offender evaluation and treatment may be part of a treatment plan in such a case.

The difference between the strictly voluntary nature of both civil protection order and domestic relations cases and the court-ordered nature of dependency and neglect cases is important to note here. Dependency and neglect courts are treatment and case management oriented, with a greater capacity to provide both ongoing monitoring of compliance and the involvement of a multidisciplinary oversight team. Further, these cases are brought by a government agency, where the aforementioned cases are brought by one of the parties to the case.

As mentioned above, civil courts are currently authorized to order offender evaluations and treatment to identify and address the individual factors leading an offender to engage in domestic violence, and such evaluation and treatment can be invaluable in ensuring that court orders are appropriate and safe. However, one important consideration is that with civil referrals there is no requirement that the individuals conducting offender evaluation and treatment services must be approved by the DVOMB. Furthermore, when civil courts do order an offender evaluation and treatment, the judicial officers are often met with resistance by the offender and / or with unwillingness by DVOMB Providers to become involved in civil cases. The resulting lack of evaluation and treatment, or provision of services by an individual who is not DVOMB approved, leaves the presenting dynamics unaddressed and leaves the court without important information for ensuring appropriate orders.

Particularly in the domestic relations and civil protection order arena, evaluation and treatment can be invaluable in ensuring that orders regarding parenting time and contact between the parties are appropriate and safe. Ideally, an offender evaluation would be ordered during the pendency of the case, so that the court would have the results at the permanent orders stage and could schedule additional hearings to ensure compliance. Such sequencing is more likely to happen in a domestic relations case than in a protection order matter. Compliance hearings, such as are being proposed here, are not standard in domestic relations and civil protection order cases and will require additional court time. Of note, the absence of compliance hearings is an area where Providers have expressed concerns and desire an alteration in court protocol. Compliance hearings are a mechanism to ensure compliance with court orders and to impose consequences for failure to comply, and without this mechanism such orders can be ignored and rendered immaterial and may even increase the risk to the survivor and the children of ongoing or amplified abuse. Increased safety risks to the victim and children can

result when the offender fails to comply with court ordered treatment and the victim is forced to report non-compliance to the court because there is no such system in place to track offender compliance.

In the dependency and neglect arena, many mechanisms are already in place to require compliance with court orders and impose consequences for non-compliance. In every case, a treatment plan, referred to as a Family Service Plan, is created based on a caseworker's assessment of each parent's and each child's individual needs. For a domestic violence offender, orders for evaluation and treatment can and should be a part of their family service plan. Dependency and neglect cases involve ongoing monitoring of progress and compliance, which better aligns with the accountability infrastructure in which Providers can safely and effectively operate. There is also often more collateral information available in dependency and neglect cases due to the county's and court's involvement. The ability for a Provider to work with a caseworker, county attorney, guardian ad litem, respondent parent counsel and others on these cases provides greater case management and accountability when implemented consistently. It is encouraged that Providers who take on dependency and neglect cases seek to establish a Multi-Disciplinary Treatment Team (MTT) with relevant stakeholders. Likewise, additional information for caseworkers and others regarding the importance and purpose of MTTs would assist in facilitating meaningful oversight. Beyond documenting an individual's attendance or non-attendance in treatment, MTTs facilitate ongoing assessment of dynamic risk factors and inform decisions about when and how an offender's contact with children should change. Without the involvement of other multidisciplinary professionals providing case management and accountability to the requirements of the treatment plan, reporting of offender non-compliance still relies on the victim. This can jeopardize victim and child safety and promote a false perception that the victim lacks capacity to protect themselves and their children.

Due to the complexity and seriousness of domestic violence, and the potential for increased safety risk when services are not specialized, professionals who work with domestic violence offenders must demonstrate competencies and expertise in domestic violence offender dynamics and victim safety. In order to become a DVOMB Approved Provider, there are educational, training, and skill-based requirements that must be met while under the supervision of a Domestic Violence Clinical Supervisor. Additionally, applicants seeking approval with the DVOMB must hold a professional mental health license or certification with the Colorado Department of Regulatory Agencies (DORA) before approval can be granted. Upon approval, these individuals are eligible to receive referrals for domestic violence offenders as defined in C.R.S. § 16-11-102, C.R.S.

The Importance of Case Coordination for Purposes of Victim Safety

The DVOMB Standards support a coordinated approach in which a Multi-Disciplinary Team is used to communicate and coordinate throughout the treatment process. To be effective, this approach must include interagency and interdisciplinary teamwork, as offender treatment cannot be successful when done in isolation from other systems. This Multi- Disciplinary Team commonly consists of a supervising agent or case manager, the DVOMB Approved Provider, a victim representative, and other adjunct professionals, where applicable. Members of this team possess critical expertise and knowledge that, once shared, can enable

improved decision-making regarding the oversight and case management among the team. This team approach enhances not only public safety but the supervision and accountability of the individual under supervision.

Common Areas of Concern

In the last few years, DVOMB has heard of an increase in requests for offender evaluation and treatment originating in civil court proceedings. In early 2019, several Providers notified the DVOMB about concerns related to working with individuals referred by a civil court order and who do not have any pending criminal charges or a recent criminal conviction related to domestic violence. The concerns raised by Providers, which are outlined below, cited issues with applying the DVOMB Standards and Guidelines to civil cases.

A. Offender Accountability: DVOMB treatment and evaluation relies on offender accountability as a key measure of initial risk and of ongoing progress throughout the treatment process. Specifically, an offender is expected to express and /or develop enhanced insight into the abusive nature of the behaviors that led to their being referred to a domestic violence offender treatment program. This is foundational to the development of an individualized plan to change future communication and problem-solving, and to redress abusive behaviors after the completion of treatment. Educating all involved parties on accountability as the cornerstone of treatment is imperative to successful treatment. The foundational need for accountability can sometimes become an impediment to an offender engaging in the treatment process, which in itself is important information regarding future risk. (See Recommendation 1)

B. Offender Evaluations: Providers are required to use various documentation and records (e.g., criminal history, police report, victim impact statement) when conducting an offender evaluation. Individuals referred by a civil court often lack this detailed documentation as to allegations or findings of domestic violence, which may impact the timeline for completing the evaluation. This may also force Providers to rely on information self-reported by the individual being evaluated, and that individual may withhold and distort facts in order to deny the offense or minimize its impact on the victim. Providers do not have access to the court in order to request additional information, should it be available. Offender evaluations under the DVOMB *Standards and Guidelines* also presume the individual being evaluated is "guilty" as the result of a criminal finding. This presumption of guilt is often protested by the referred party in civil cases because admissions of abusive behavior may introduce constitutional issues of due-process regarding self-incrimination. Such concerns can lead to resistance to participating in the offender evaluation. The referred party may be concerned that an offender evaluation substantiating domestic violence behaviors could impact civil court proceedings (e.g. parenting time, decision making, protection order) in ways they do not want it to. Further, there are currently few consequences that can be imposed by a civil court for someone who refuses to undergo an offender evaluation. Individuals who do undergo a domestic violence offender evaluation often contest the results and the validity of any treatment recommendations included. Despite these concerns, the purpose of an offender evaluation is not to determine guilt or innocence but rather to assess the referred party's need for treatment, determine what type of treatment is needed, and identify the risk level and any additional needs the offender may have related to

containment, stabilization and safety. (See Recommendation 1 and 2)

C. Court Oversight for Engagement in Offender Treatment: As noted above, parties referred for domestic violence offender treatment who do not have pending criminal charges or a recent criminal conviction related to domestic violence are reported to be highly resistant and less amenable to starting treatment. Historically, penalties or consequences have not been imposed for individuals referred by a civil court who fail to participate in treatment. This has subsequently led to high drop-out rates which implicates victim safety. The utilization of offender evaluation and treatment by a DVOMB Approved Provider has not yet materialized due to barriers in the civil arena. Addressing these issues at the policy and implementation level may facilitate more availability of Providers as well as interest by individuals in the civil legal arena. (See Recommendation 2 and 3)

D. Liability and Complaints: Providers report concerns with accepting offenders who are referred by civil courts due to having experienced a higher percentage of these clients filing complaints against their licensure or certification through the Colorado Department of Regulatory Agencies (DORA). While overwhelmingly the complaints allege practice out of scope and are subsequently dismissed as unfounded, the increased potential of being grieved has a chilling effect on providers accepting civil referrals. Providers note the risk to their licensure, the additional time and energy associated with responding to formal complaints, and potential increases in cost for liability insurance as factors that disincentivize their accepting these referrals. It is believed that current ambiguity regarding guidelines for Providers when accepting civil referrals contributes to a higher incidence of grievances being made by this population. Were there to be guidance from the DVOMB on these cases, Provider concerns regarding how their actions may be understood by regulatory bodies would be mitigated. (See Recommendation 1)

E. Case Management Support Systems: Domestic violence offender treatment requires accountability and enforcement measures that do not currently exist in civil cases originating from domestic relations and child welfare cases. The DVOMB *Standards and Guidelines* are constructed with a multi-disciplinary approach to the case management of offenders as they progress in treatment. In criminal cases, a supervising agent (e.g., probation officer or a parole officer) will coordinate and communicate with a Provider, serving as a way to provide containment of the offender while in the community. Providers are reluctant to take on civil cases without the multidisciplinary support required for effective monitoring or containment of the offender. Without multidisciplinary support, Providers report having to serve in a dual-role as the therapist as well as the supervising agent. This is particularly concerning with higher risk individuals, when repeat offenses or escalated violence is occurring. Dependency and neglect cases have better infrastructure to operationalize this multidisciplinary work, as compared to cases from a domestic relations or protection order court. Addressing current practices within the Division of Child Welfare and training at the county level regarding how case workers can participate in the multidisciplinary treatment team would result in better outcomes in these cases. Domestic relations and civil protection order matters present a different set of challenges in that these are not treatment courts and do not have the means to monitor offender compliance that exists in dependency and

neglect matters or criminal courts. Without a system in place to track offender compliance and prioritize victim safety, victims themselves are forced to seek the assistance of the court when the offender fails to comply with court ordered treatment, placing them in the dangerous position of engaging the court at a time when their safety may be at the greatest risk. (See Recommendation 2 and 4)

F. Within civil protection order and domestic relations courts, judicial officers and court personnel (including court-appointed professionals such as child and family investigators and parental responsibility evaluators) are typically not familiar with the DVOMB or its function. This is true for attorneys operating in this realm as well. In addition, notably, 85 percent or more of litigants in these matters are not represented by attorneys and thus likewise are typically not familiar with the DVOMB or its function. In addition to the lack of knowledge of DVOMB as a resource, these systems are not designed for ongoing monitoring or accountability outside of the pendency of the case, which can be anywhere from two weeks to a year. This is due to a number of factors including lack of court resources and lack of statutory guidance for judicial personnel and others working in this system.

G. Funding for Services: County child welfare services primarily use CORE dollars to pay for evaluations and services needed in Dependency and Neglect cases. There are limitations on the use of CORE funding for offender services; however, it is not clear where this restriction is defined. At the time of this publication, it appears there is inconsistent access to CORE funding - some jurisdictions have been able to use CORE funding for evaluation and treatment services of a Provider. Other jurisdictions have reported the opposite. Without supplemental funding to pay for Provider services, reliance on a self-pay model acts as a disincentive to those being referred and increases their initial resistance to undergo an evaluation. Within civil protection order and domestic relations courts, there are no established sources of funding for evaluation or needed treatment services. In fact, any costs associated with these matters are strictly the responsibility of the parties and are allocated at the court's discretion, meaning a victim could be required to assist with the cost of an offender's evaluation and treatment. (See Recommendation 4)

H. Treatment Victim Advocacy: Under the DVOMB *Standards and Guidelines*, a Treatment Victim Advocate (TVA) is utilized as part of the multi-disciplinary approach to treatment. TVAs are unique to the DVOMB *Standards and Guidelines* and are distinctly different from community-based advocates and system-based advocates. Both community-based advocates and system-based advocates are defined in statutes that specify their level of confidentiality and privilege while working with a victim of domestic violence. Treatment Victim Advocates, on the other hand, are defined in the DVOMB *Standards and Guidelines*, which are a derivative of its statutory authority to create standards for individuals who are convicted and sentenced according to § 16-11.8-103(4)(a)(II) C.R.S. for crimes which meet the statutory definition of domestic violence. As a result, the authority and scope of a TVA is limited to criminal cases. The use of a TVA in a civil case to promote the multi-disciplinary approach could be disputed on the grounds that the TVA is codified in the DVOMB Standards, which are intended for criminal-involved populations. Unlike community-based domestic violence victim advocates, TVAs do not have any confidentiality or privilege

and their engagement could jeopardize victim safety in civil cases. This concern may be reconciled by clarifying the purview of the DVOMB to include civil cases and defining the role and purpose of TVA's in statute. (See Recommendation 1)

Recommendations

1. *Broaden the purview of the DVOMB to include domestic violence cases arising from civil courts*

Much has changed in the understanding of domestic violence in the years since 2008 when the DVOMB enabling statutes were last modified. Requests for Providers to work with offenders in civil cases are increasing, and Providers want guidance to do so effectively. Providers represent a qualified body of professionals who are uniquely trained and skilled to provide services with this population. The DVOMB is currently unable to promulgate any guidance to Providers because the board's purview is limited to criminal cases. As a result, there is a lack of standardization in how civil cases are approached and overseen with regard to the evaluation and treatment of domestic violence offenders. Additionally, access to funding for these services is often limited.

Changes in statute may alleviate these barriers by expanding the purview of the DVOMB in order to authorize its role in the creation of *Standards and Guidelines* for civil cases. This would require broadening the definitions in § 16-11.8-102(2), C.R.S. to include a more comprehensive definition of a domestic violence offender to include someone who engages in domestic abuse as defined in § 13-14-101(2), C.R.S. or domestic violence as defined in § 14-10-124 (1.3)(a), C.R.S. This would also necessitate clarifying the DVOMB's purview in § 16-11-103(4)(a)(2), C.R.S.

2. *Update the Best Interest of the Child Standard to align with requirements to use a DVOMB Approved Provider and Ensure Compliance*

Currently, the Best Interest of the Child Standard (§ 14-10-124, C.R.S.), used to address parenting time and decision-making in cases involving allocation of parental responsibility and care and control of minor children in civil protection order matters, includes domestic violence offender evaluation and treatment as something a court may order if a party is found to have committed domestic violence[21]. However, the language in § 14-10-124 (4)(f), C.R.S. does not mention the DVOMB and does not provide any guidance to the court, court-ordered professionals, or family law practitioners regarding how any ordered domestic violence offender evaluation and treatment is to be achieved.[22]

[21] Domestic violence is not generally addressed in these cases unless the parties share children. As Colorado is a no-fault divorce state, issues such as property division, spousal maintenance, or other matters that courts address whether or not there are children involved, do not currently take a history of DV into consideration.

[22] "When the court finds by a preponderance of the evidence that one of the parties has committed domestic violence, the court may order the party to submit to a domestic violence evaluation. If the court determines, based upon the results of the evaluation, that treatment is appropriate, the court may order the party to participate in domestic violence treatment. At any time, the court may require a subsequent evaluation to determine whether additional treatment is necessary. If the court awards parenting time to a party who has been ordered to participate in domestic violence treatment, the court may order the party to obtain a report from the treatment provider concerning the party's progress in treatment and addressing any

While the statute provides that the court may review a report obtained from the Provider and use that to determine future court orders, the statute does not designate the qualifications needed for Providers or provide a framework for working with Providers, monitoring progress, ensuring accountability, or multidisciplinary collaboration. Court ordered treatment must also account for parenting deficits using validated interventions that are designed for domestic violence offenders, such as Caring Dads[6]. Further, domestic relations and protection order/county courts are not equipped to oversee a process that includes these factors.

In order to address these concerns, the statute would need to include several changes:

1. All domestic violence evaluations and treatment ordered by these courts must be provided by DVOMB Approved Providers. Section 14-10-124(4)(f), C.R.S. should be amended to make this explicit.
2. Court orders for DV offender evaluation and treatment must include specific documentation and information, such as detailed findings regarding the domestic violence, any evidence on which the court relied in making such findings, and any other information the court believes will assist the evaluator in assessing the

   offender's need for treatment and determining what type of treatment is needed (if any). Parties should not be ordered to complete an evaluation for purposes of making such a finding.
3. Victims of domestic violence should be advised by the court that they may be contacted by a DVOMB Approved Provider's agency or practice, of the purpose of the evaluation, of the role of the TVA, and that they may choose to participate in the evaluation and treatment process. Furthermore, victims should be encouraged to seek support from a confidential community-based domestic violence victim services agency and offered resources to locate one in their community.
4. Victims should not be ordered to pay for offender evaluations, treatment or any other cost that is a result of the offender's abusive behavior. Such orders undermine the goals of treatment, burden victim finances, and place the responsibility for the offender's behavior on the wrong person.
5. The legislature must address the lack of infrastructure and lack of funding that allows offenders to avoid compliance with civil court orders and limits the consequences for failure to comply with findings of contempt of court and subsequent remedial or punitive measures.

3. Enhance and Strengthen Civil Protection Order Statutes

The civil protection order process, while quite different from the domestic relations process, is similar in the way the Best Interest Standard is used to address parental responsibilities. However, due to the abbreviated nature of that process[7], courts are less likely to order an evaluation and treatment while the case is ongoing. Additionally, where there are children involved, judicial officers frequently decline to address the care and control of children (short-term orders regarding parenting time and decision-making responsibility), requiring

ongoing safety concerns regarding the party's parenting time. The court may order the party who has committed domestic violence to pay the costs of the domestic violence evaluations and treatment."

victims to file cases in domestic relations court instead. This undermines victim autonomy and reduces the effectiveness of the civil protection order in achieving victim and child safety. Because judicial officers assume that a victim seeking a civil protection order will not have further contact with the offender, they are most likely to order offender evaluation and treatment in cases where the parties share children. These concerns present additional challenges for updating the statute. Changes to the protection order statute that may assist in this are:

1. Provide the court with continuing jurisdiction to address compliance both during the pendency of a temporary protection order, which may be issued for up to one year, and throughout the existence of a permanent protection order, which is no less than two years and can remain in place indefinitely.
2. Require courts to issue care and control orders when requested by either party, and specify that the reference to §13-14-105(e)(IV), C.R.S. includes all possible remedies outlined in §124-10-124(4), C.R.S.
3. Address the same concerns outlined in subparagraph 2 above.

4. Direct the Colorado Department of Human Services to promulgate policy and procedural changes needed sustain ongoing case coordination with treatment

The Colorado Department of Human Services' Child Welfare Sub-Policy Advisory Committee should ensure that any orders for domestic violence offender evaluation and treatment comply with § 16-11.8-104(1) that mandates the department of human services to refer to only DVOMB Approved Providers. It may be beneficial for there to be similar language in Title 19 that reflects this requirement for the Colorado Department of Human Services.

Expanding the purview of the DVOMB and its mandates to civil cases would likely also reconcile the issues with using Treatment Victim Advocates in non-criminal cases. This group should also address the ability of county departments of human services to use CORE dollars or other funding streams to fund Provider services.

5. Caseworker Involvement in Promoting Accountability and Engagement in Treatment Within Child Protection

The primary tool to orient caseworkers on addressing domestic violence is the Domestic Violence Practice Guide for Child Protective Services (Practice Guide). This tool, created by the State Division of Child Welfare, is intended to support case practice when domestic violence and child maltreatment concerns are co-occurring. However, it is reported that the Practice Guide is underutilized by case workers and predates the adoption of Differential Response. Underutilization of the Practice Guide is attributed to ongoing turnover with case workers, a lack of standardization in training expectations regarding this content, and limited opportunities for case workers and supervisors to be trained on the Practice Guide and its use. The impact of this underutilization is that Providers who want to engage with caseworkers frequently need to provide additional training and guidance as to the core dynamics of domestic violence, offender pathologies, and treatment approaches.

It would be helpful to Providers if initial and ongoing training on such content were provided to caseworkers, which could be achieved through standardized training on and application of the Practice Guide. The Practice

Guide may assist caseworkers in understanding how to engage with offenders. Beyond this individual approach, finding ways for caseworkers to meaningfully partner with DVOMB providers and other MTT professionals will enhance the information available to dependency and neglect courts for case decision making and the likelihood of offender engagement. Caseworker actions and MTT oversight together would reduce the risk of future abusive behaviors and / or would flag the need for additional containment to achieve safety.

Conclusion

Due to its lack of statutory purview, the DVOMB cannot direct Providers as to whether or not and to what extent the DVOMB *Standards and Guidelines* should be applied to offenders referred through civil court orders. However, Providers have the training and expertise to address the presenting symptom profiles of people being referred regardless of whether the referral originates from a criminal or a civil context.

The DVOMB is uniquely positioned to provide structure and support that enables Providers to accept offenders referred from civil cases and for TVAs to participate in these matters.

Without said support, there is a large gap in services leaving systems unable to provide for families impacted by domestic violence. Because civil legal systems are ill equipped to support and prioritize victim and child safety, these issues are overlooked and the current system is often misused to the detriment of the victim and their children.

Appendix D. Formative Research Results from Orange Circle Consulting Regarding Provider Recruitment

Executive Summary (Click here for access to the report)

Report (Click here for access to the report)