DOMESTIC VIOLENCE OFFENDER MANAGEMENT

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 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.

This report is a product of the Domestic Offender Management Board (DVOMB) as mandated by Section 16-11.8-103(5.5)(a), C.R.S. This report and the recommendations herein do not necessarily represent the views of Colorado's Governor's Office, Office of State Planning and Budgeting, the Colorado Department of Public Safety, or other state agencies.

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. Recent meta-analyses have found domestic violence treatment programs can be effective at reducing domestic violence and general recidivism (e.g.,Gannon, Olver, Mallion, & James, 2019; Travers, McDonagh, Cunningham, Armour, & Hansen, 2021) when they adhere to the Risk-Need-Responsivity (RNR) principles (Andrews, Bonta, & Hoge, 1990: Bonta & Andrews, 2017). Travers et al.'s (2021) meta-analysis found programs that adhered fully to the RNR principles had the largest reductions in domestic violence recidivism, while partial adherence was less effective but better than no treatment.

Dynamic Risk Factors and Lethality Risk Factors for Domestic Violence Recidivism

Addressing and reducing dynamic risk factors that are empirically associated with recidivism is the focus of treatment according to the Need Principle. In the RNR model, these needs are termed 'criminogenic' needs to highlight their strong association with recidivism, in contrast to other 'non-criminogenic' needs that may be present but have a weak or no association with future offending. An important focus of research in the domestic violence field is determining the set of dynamic risk factors, or criminogenic needs, that should be addressed and monitored in treatment programs and supervision for domestic violence. Conceptually, dynamic risk factors are the characteristics of a person or situation that predict future domestic violence and severity of harm to victims that are *potentially changeable* via intervention or maturation.

[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.

Taken together, the research converges to indicate domestic violence recidivism is predicted by several of the broad criminogenic needs or domains articulated in the RNR model that are predictive of general recidivism including marital-family problems,[2] antisocial personality traits, substance use problems, employment problems, antisocial attitudes or beliefs, emotional-mental health problems, and to a lesser extent, antisocial associates. The research review also indicated a range of more specific risk factors for domestic violent offending include emotional-psychological-verbal abuse, controlling behaviors, demand-withdrawal relationship patterns, jealousy, relationship conflict, approval of domestic violence, and externalization of blame. Finally, one notable dynamic risk factor of relevance to severe domestic violence is direct access to guns.

Validation Study of the Colorado Domestic Violence Risk and Needs Assessment

The Colorado Domestic Violence Risk and Needs Assessment (DVRNA) is a structured risk assessment used to evaluate and place domestic violent offenders into differential domestic violence treatment levels in Colorado. The DVRNA is composed of 14 risk domains (e.g., prior domestic violence-related incidents), each with a range of risk items indicative of that risk factor. The total DVRNA score corresponds to a recommended domestic violence treatment placement level that varies by low, moderate, or high intensity. The DVRNA operationalizes the Risk and Need principles of the RNR Model.

The DVRNA was evaluated in 2023 to examine its predictive validity and with a view towards revising it to improve its predictive accuracy, utility for treatment planning and monitoring, and ease of use. The validation study included 787 individuals referred for domestic violence offender evaluation between October 2018 and August 2021[3]. The recidivism data[4] (e.g., new filings) included all charges except minor traffic or petty offenses received during the follow-up period shown in **Table 1**.

Table 1. Placement Level for Cases with and without Recidivism (N=787).

Treatment Level	No DV Charges[a] n (%)	DV Charges[b] n (%)	No Charges[c] n (%)	Any Charges[d] n (%)
A (low intensity)	23 (96%)	1 (4%)	19 (79%)	5 (21%)
B (moderate intensity)	162 (91%)	16 (9%)	142 (80%)	36 (20%)
C (high intensity)	420 (72%)	165 (28%)	348 (60%)	237 (40%)

a. No DV Recidivism included individuals without any charges for DV-related offenses.
b. DV Recidivism included individuals with charges for DV, Violation Protecton Order, or Child Abuse/Assault offenses.
c. No Recidivism included individuals with no charges for any offenses.
d. Any Recidivism included individuals with one or more charges for any offenses, excluding petty crimes.

[2] In the RNR Model, this general criminogenic need includes dissatisfaction within the current relationship due to a range of stressors, non-rewarding parental relationships, and/or family members involved in criminal activities.

[3] These data were collected prior to the data collection requirement from House Bill 22-1210 in June 2022.

[4] The follow-up period included from the date of the DVRNA assessment date to the recidivism data extraction date of November 1, 2022, with the mean follow-up length being 2 years (748 days, SD=161 days).

The findings from the DVRNA validation study include:

- The DVRNA placement level separated study group members into valid risk groups that differed by recidivism rates and examination of the DVRNA total score showed it had small to moderate predictive accuracy.

- Examination of the individual domain risk factors revealed some risk domains underpinned the effectiveness of the DVRNA, while others did not add significantly.

- The study findings indicate the DVRNA is a valid instrument, and also highlights the potential for improvement. The findings suggest that refinement of the risk domains, and items that contribute within the domains, could create an equally or more predictive instrument that is streamlined and easier to administer. An opportunity to revise the dynamic risk factors to incorporate advancements in dynamic risk assessment and treatment planning also exists. In its present form, the DVRNA mixes dynamic and static risk factors, whereas it would be better if there were separate static and dynamic parts to the instrument as this would facilitate reassessment of dynamic risk factors across treatment.

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

1. *Issues related to Cannabis Use with Domestic Violence Offenders*

   The link between domestic violence and substance use is established for the use of alcohol (Langenderfer, 2013), illicit drugs (Choenni, Hammink, & van de Mheen, 2017), substance use on the same-day of the abuse (de Bruijn & Graaf, 2016) or as part of ongoing dependence (Stuart et al., 2009), and transcend nearly every culture, class, region, and country (Duvvury, Callan, Carney, & Raghavendra, 2013; Eng, Li, Mulsow, & Fischer, 2010). This link can be found across samples with justice-involved and non-justice involved populations. Cannabis use has historically and culturally been perceived as a safer alternative over other substances because cannibus use is typically associated with mild euphoric states, relaxation, less aggression, and violence. Emerging research related to intimate partner violence is challenging this notion. In a recent meta-analysis examining the relationship between substance use and domestic violence it was found “that the strength of the link between marijuana use and perpetration or victimization is on par with substances more typically associated with IPV, such as alcohol, cocaine, or amphetamines” (Cafferky et al., 2018, pg. 119).

   It is important to note that domestic violence is not caused as a result of substance use or misuse. Rather substances can facilitate or exacerbate an offender’s other risk-related propensities such as attitudes and behaviors that are

rooted in a belief system supportive of domestic violence. Cannabis use while in treatment is associated with poorer short-term outcomes (Subbaraman, Metrik, Patterson, & Swift, 2017), at least in part because offenders using substances struggle to externalize and apply what is learned in treatment due to the related impairment in neurocognitive functioning (Dellazzazio et al., 2020).

Recommendation: There is sufficient evidence now that links cannabis with domestic violence across a variety of samples. It is based on the research and literature to date that the DVOMB recommends that the legislature statutorily require the DVOMB to conduct a study examining how the use of cannabis by domestic violence offenders is associated with domestic violence offender treatment participation, compliance, outcomes, and victim safety.

2. *Public Safety Considerations and Policy Implications with Restorative Justice in Domestic Violence Cases*

The crime of conviction is not indicative of the risk for future recidivism when looking at domestic violence offenders. When compared to the general offending population, domestic violence offenders have been found to possess more criminogenic needs (Hilton & Radatz, 2018) and recidivate at a higher rate (Flick & English, 2016; Gondolf, 1997b, 2003). Restorative Justice (RJ) has recently emerged as a newfound way of addressing intimate partner violence, however, there are prevailing concerns. There is limited empirical research documenting the use of RJ with domestic violence and it presents possible risk to victims. The research supporting the use of RJ with domestic violence cases relies on anecdotal and at best, cross-sectional studies; some of which have not been peer-reviewed. There are some key considerations when looking at the use of RJ in domestic violence cases.

- The risk for re-offense and for lethality vary based on a myriad of factors and those who work with domestic violence offenders require training, competencies, and expertise in domestic violence offender dynamics and victim safety. RJ Practitioners are not regulated in the State of Colorado and there are no requirements presently for training, background checks, or supervision prior to becoming an RJ Practitioner. There are no parameters guiding who may or may not be eligible for becoming an RJ Practitioner, including criminal history. This means that current or former domestic violence offenders, who may or may not have undergone domestic violence offender treatment, could act as an RJ Practitioner or Facilitator.

- Domestic violence does not stem from a failing relationship. Domestic violence is the result of a pattern of coercive control removing a victim's freedom, degrading their dignity, and creating conditions that place blame on the victim. By failing to build a response around these underlying dynamics of intimate partner violence, it gives a way for a RJ program to potentially cause further harm and re-traumatize victims. Victims being presented with the option of RJ may be unknowingly coerced, forced, or otherwise manipulated by an offender to agree. Additionally, victims may be blamed for causing the abuse that was perpetrated against them and may not be open and honest out of a fear the offender will retaliate.

Recommendation: Further data and research is needed to examine the effects and implications of RJ Programs prior to the adoption and implementation of broad policies or statutory changes regarding RJ Programs for domestic violence offenders.

Section 3: Milestones and Achievements

The following highlights some of the many additional achievements of the DVOMB in FY2022-2023:

- Managed six DVOMB committees
- Approved 74 applications for placement or continued placement on the DVOMB Approved Provider List during FY 2022-2023.
- As of July 2023, there were 153 active and 32 not currently practicing treatment DVOMB Approved Providers in Colorado. Of those treatment providers, 111 **are approved to work with female offenders** and **44 are approved to work with LGBTQ+ offenders.**
- Conducted 38 trainings to over 1,400 attendees from across Colorado. These trainings covered a range of topics related to the treatment and supervision of individuals convicted of domestic violence offenses. This included cohosting a four-day conference for DVOMB Approved Providers, supervising officers, victim advoacates, law enforcement, court personnel, and other stakeholders.
- Validated the Colorado Domestic Violence Risk and Needs Assessment (DVRNA) regarding its ability to determine the appropriate treatment level for domestic violence offenders at the time of assessment.
- Supported monthly Technical Assistance hours. On a monthly basis, DVOMB staff hosted two virtual, one-hour technical assistance sessions for DVOMB 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.
- Shared findings with stakeholders about the characteristics that attract potential and current DVOMB Approved Providers to the field identified in the formative research conducted with Orange Circle Consulting. This effort is to create a communication and recruitment strategy to increase the number of DVOMB Approved Providers across Colorado with specific focus on diversity, equity, and inclusion.
- Implemented requirement for DVOMB Approved Provider to submit client service-level data related to domestic violence offender services as part of HB2022-1210.

Section 1: Research and Evidence-based Practices

Dynamic Risk Factors and Domestic Violence Treatment

Recent meta-analyses have found domestic violence treatment programs can be effective at reducing domestic violence and general recidivism (e.g.,Gannon, Olver, Mallion, & James, 2019; Travers, McDonagh, Cunningham, Armour, & Hansen, 2021). One factor found to moderate the degree of effectiveness is adherence to the Risk-Need-Responsivity (RNR) principles of effective practice (Andrews, Bonta, & Hoge, 1990: Bonta & Andrews, 2017). Travers et al.'s (2021) meta-analysis found programs that adhered fully to the RNR principles had the largest reductions in domestic violence recidivism, while partial adherence was less effective but better than no treatment.

The RNR model is a broad framework for organizing the delivery of offender interventions and supervision that has been incorporated into the *Standards and Guidelines*.[5] In the RNR model, the risk principle involves matching treatment intensity to risk level, with higher risk individuals receiving more intensive treatment than lower risk individuals. The need principle directs treatment to focus on addressing and reducing dynamic risk factors that are empirically associated with recidivism. In the model, these are termed 'criminogenic' needs to highlight their strong association with recidivism, in contrast to other 'non-criminogenic' needs that may be present but have a weak or no association with future offending. The responsivity principle involves programs using empirically informed treatment approaches that promote engagement and learning while also encouraging program adaptations for individual needs such as cultural heritage, cognitive functioning level, language barriers, and trauma histories.

An important focus of research in the domestic violence field is determining the set of dynamic risk factors, or criminogenic needs, that should be addressed and monitored in treatment and supervision for domestic violence. Conceptually, dynamic risk factors are the characteristics of a person or situation that predict future domestic violence and severity of harm to victims that are *potentially changeable* via intervention or maturation.[6] Dynamic risk factors contrast with static risk factors that are also predictive but unchangeable (e.g., past domestic violence convictions); although both may arise from similar underlying risk-related propensities such as particular personality traits, poor emotion regulation, or maladaptive belief systems (Brankley et al., 2021). While Travers et al.'s (2021) meta-analysis is informative and supports the importance of a focus on criminogenic needs, it does not

[5] The model is underpinned by a series of principles of effective intervention, of which the risk-need-responsivity principles are the most well-known and evaluated.

[6] In the nested ecological model of domestic violence (Dutton, 1995), four levels of causal factors for domestic violence are identified, namely the macrosystem level (societal factors such as cultural attitudes, beliefs, and laws), exosystem level (social structures and community factors such as employment opportunities and support systems or lack thereof), microsystem level (setting and situational factors such as the relationship), and ontogenetic system level (individual factors such as perpetrator's cognitive, emotional, and behavioral characteristics). Research into risk factors for domestic violence perpetration can examine all four levels, although to-date it tends to emphasize individual (ontogenetic) and relationship (microsystem) factors as these are what can be addressed in treatment and supervision.

provide a comprehensive account of what are the relevant criminogenic needs or dynamic risk factors.[7] The RNR model articulates a set of criminogenic needs associated with recidivism generally (e.g., antisocial personality traits), yet the extent these relate specifically to domestic violence recidivism and victim safety is still being established.[8] The criminogenic needs in the RNR model also reflect broad dynamic risk domains that potentially contain other more specific risk factors (Fortune & Heffernan, 2021), so there is a need to consider what these more specific dynamic risk factors might be for domestic violence treatment and supervision.

As part of the DVOMB's statutory mandate and commitment to develop evidence-based *Standards and Guidelines*, it is important to conduct relevant research reviews and updates.[9] In 2023, a review of recent research examining the dynamic risk factors for domestic violence was completed. The review sought to select and summarize relevant findings from more recent, higher quality research. The review also considered whether the major findings applied equally across individuals from different racial-ethnic heritages, the female gender, and LGBTQ+ identities. Where the research identified protective factors that reduced domestic violence recidivism and supported desistance, this was also highlighted. As many of the dynamic risk factors, and the risk-related propensities underlying them, may have developed from adverse childhood experiences or trauma, the implications for trauma-focused care are also discussed. A highlight of the review findings is provided below organized into the following sections: (i) Dynamic risk factors and lethality risk factors for domestic violence, (ii) Protective factors and trauma-senstive care in support of desistance, and (iii) Implications for the DVOMB *Standards and Guidelines*.

Summary of Literature and Research

Dynamic Risk Factors and Lethality Risk Factors for Domestic Violence Recidivism

A small number of studies have examined dynamic risk factors predictive of *domestic violence recidivism* in individuals already convicted for domestic violence offenses. A major strength of these studies, for this purpose, is that the participants are most similar to the group who are subject to domestic violence treatment under the *Standards and Guidelines*. Hilton and Radatz (2021), for example, examined whether a subset of the criminogenic needs in the RNR model associated with general recidivism predicted domestic violence recidivism. The study found antisocial personality traits, antisocial attitudes, substance use, and employment/school problems predicted domestic violence recidivism in over 1,400 men charged with domestic assault. Further, those men who engaged in domestic violence recidivism had a greater overall number of these dynamic risk factors than men who did not engage in domestic violence recidivism. In other studies involving criminal justice-involved individuals who committed domestic violence offenses, anger problems, unemployment, and substance abuse problems were found to predict subsequent domestic violence recidivism (Farzan-Kashani &

[7] In the Travers et al. (2021) meta-analysis, programs were coded positively for addressing the need principle if there was evidence of addressing one or more of the set of criminogenic needs put forth as part of the RNR model (Bonta & Andrews, 2017). The analysis did not specify which crimogenic needs were targeted or examine which changes were associated with reductions in recidivism.

[8] The RNR criminogenic needs are antisocial personality patterns, prociriminal attitudes, social supports for crime, substance abuse, poor family/marital relationships, poor school/work performance, and low levels of prosocial recreational activities (Andrews et al., 1990; Bonta & Andrews, 2017).

[9] Colorado Revised Statute 16-11.8-103 (4)(a)(IV).

Murphy, 2017; Gersetenberger, Stansfield, & Williams, 2019; Grace, McNary, & Murphy, 2022; Peters, Nunes, Ennis, Hilton, Pham, & Jung, 2022).

A large number of studies have examined potential dynamic risk factors *associated with domestic violence* in individuals either sanctioned for a domestic violence offense or who self-report having committed domestic violence. A limitation of these studies is that they do not establish that these factors *predict* new domestic violence recidivism; however, they do offer support for the broad domains of criminogenic need identified above as well as highlight more specific domestic violence risk factors within these domains. For example, research found men convicted of domestic violence had high rates of marital-family problems[10], substance abuse, antisocial personality traits, antisocial attitudes, antisocial associates, and emotional-mental health problems (Hilton & Radatz, 2018; Stewart & Powers, 2014). A large meta-analysis of combined justice-involved and community samples found other non-physical forms of domestic violence (e.g., emotional abuse, threats, and stalking) were the strongest correlates of physical domestic violence perpetration by males and females, followed by relationship problems (e.g., arguments, demand-withdrawal communication style, borderline personality traits, and controlling behaviors), and individual characteristics (e.g., anger, approval of violence, narcissism, antisocial personality disorder, mental health problems, jealousy, access to weapons, alcohol and drug use, and impulsivity) (Spencer, Stith, & Caeferty, 2022). Another meta-analysis found the presence of greater psychopathic personality traits was also a significant correlate of domestic violence perpetration (Robertson, Walker, & Frick, 2020).[11]

Studies into the risk factors for domestic violence homicide and domestic violence sexual assault also shed light on *salient* dynamic risk factors associated with greater harm and lethality to victims. A meta-analysis of male perpetration of completed or attempted domestic violence homicide against a female found the perpetrator's direct access to guns increased the likelihood by 11 times, while previous severe domestic violence (i.e., threatened victim with a weapon, nonfatal strangulation, and rape/forced sex) increased the likelihood upwards of five times (Spence & Stith, 2020). Additional dynamic risk factors were controlling behaviors, jealousy, substance abuse, and to a lesser degree, mental health issues. The risk for lethality also approximately doubled when the victim was separated from the perpetrator. In a separate study of domestic violence homicide case reviews, almost three quarters of the perpetrators (73%) had a history of domestic violence, making it the most common risk factor, followed by actual or pending separation (70%), obsessive behavior (54%), depression (50%), prior threats or attempts to commit suicide (49%), escalation of violence (48%), prior threats to kill the victim (43%), unemployment (40%), and attempts to isolate the victim (39%) (Dawson & Piscitelli, 2021). Victims' intuitive sense of fear was also present at high rates (45%).

An important question concerning the research is the extent to which the major findings apply across individuals from different racial-ethnic heritages, the female gender, and LGBTQ+ identities. Although the research samples are predominantly white, many studies include representative proportions of African American, Hispanic-Latino, and Indigenous individuals, and some specifically examine findings by racial-ethnic group. For example, a research review by Lee and colleagues (2022) found support for alcohol abuse as a dynamic risk factor for the perpetration of domestic violence by African American

[10] In the RNR Model, this general criminogenic need includes dissatisfaction within the current relationship due to a range of stressors, non-rewarding parental relationships, and/or having family members who are involved in criminal activities.

[11] Psychopathic personality traits reflect a constellation of antagonism/callousness, disinhibition/impulsive-irresponsible behavior, and fearless grandisosity (narcissism, emotional stability, boldness) (Sellbom, Liggins, Laurinaityte, & Cooke, 2021).

men, while Stewart and Powers (2014) found higher rates of criminognic needs in Indigenous, compared to non-Indigenous, men with domestic violence offenses. Recent comprehensive reviews of female perpetration of domestic violence emphasize that the risk factors and motivations for female perpetrators are more similar than different to those for male perpetrators (Bowden & Mackay, 2019; Dowd & Lambo, 2022; Hines & Douglas, 2022). In keeping with this, the meta-analysis by Spencer et al. (2022) found that of 44 risk correlates of physical domestic violence, only 9 significantly differed between females and males.[12] Research addressing the need to understand domestic violence for people with LGBTQ+ identities and relationships is also developing. Two extensive reviews concluded parallels existed between heterosexual and same-sex domestic violence, although some unique factors included sexual health issues, threats of "outing," sexual minority stress, and lack of tailored support services (Callan, Corbally, & McElvaney, 2021; Rolle, Giardina, Caldarera, Gerino, & Brustia, 2018).

Taken together, the research converges to indicate domestic violence recidivism is predicted by several of the broad criminogenic needs or domains articulated in the RNR model that are predictive of general recidivism. These broad dynamic risk factors include marital-family problems[13], antisocial personality traits, substance use problems, employment problems, antisocial attitudes or beliefs, emotional-mental health problems, and to a lesser extent, antisocial associates. A feature of these established criminogenic needs is that they reflect broad risk domains that likely contain a number of more specific risk factors (Fortune & Heffernan, 2021). Consistent with this, the research review also indicated a range of more specific risk factors for domestic violent offending include emotional-psychological-verbal abuse, controlling behaviors, demand-withdrawal relationship patterns, jealousy, relationship conflict, approval of domestic violence, and externalization of blame. Finally, one notable dynamic risk factor of relevance to severe domestic violence is direct access to guns.

Protective Factors and Trauma-Sensitive Care in Support of Desistance

Alongside examining the dynamic risk factors associated with domestic violence recidivism and harm to victims, research has begun to expand attention to identifying protective factors that counterbalance or mitigate risk and contribute to desistance (de Vries Robbé et al., 2013; Walker, Bowen, & Brown, 2013). Conceptually, some protective factors may be the opposite extreme of dynamic risk factors (e.g., prosocial attitudes vs. antisocial attitudes), while others may promote desistance independent of dynamic risk factors (e.g., life goals or medication use). Incorporating recognition of protective factors within treatment and supervision fits with using strengths-based approaches that may facilitate engagement and motivation, as well as allow further individualization of treatment and risk management (Burghart et al., 2023). In terms of treatment planning, for example, it draws attention to positive factors that should be sustained through treatment and to insufficiently developed areas that should also be the focus of clinical services.

A large meta-analysis of mixed justice-involved and community samples found the degree of physical domestic violence was mitigated by greater internal locus of control (i.e., personal agency and responsibility), relationship satisfaction, communication skills, coping skills, conflict resolution skills, higher income, empathy, higher self-esteem, higher education, and older age (Spencer et al., 2022). A review of research examining the prevalence of domestic violence following incarceration found

[12] In 8 of those instances the difference was small.

[13] In the RNR Model, this general criminogenic need includes dissatisfaction within the current relationship due to a range of stressors, non-rewarding parental relationships, and/or having family members who are involved in criminal activities.

substance abuse treatment in prison, healthy relationship beliefs, improved conflict resolution and relationship trust, and older age were protective and part of the desistance process (Stansfield et al., 2022). Employment was also found to be a protective factor against male perpetration of domestic homicide against female victims (Spencer & Stith, 2020). A recent meta-analysis of the Structured Assessment of Protective Factors for general violence risk (SAPROF; de Vogal et al., 2012) also found many of the same protective factors were predictive of lower rates of violent recidivism (e.g., physical assault) and that measuring protective factors alongside risk factors increased the accuracy of predictions (Burghart et al., 2023). The SARPOF items appear to measure components of resilience (e.g., self-control, coping, attitudes to authority, work, intelligence, and financial management), reintegration (e.g., leisure activities, social network, and intimate relationships), treatability (e.g., professional care, medication, motivation for treatment, empathy, and life goals), and living conditions (e.g., living circumstances and external controls) (Abbiati, Golay, Gasser, & Moulin, 2020).

It is well-accepted that many of the dynamic risk factors for domestic violence will have developed from, or been exacerbated by, adverse childhood experiences (e.g., childhood abuse and witnessing domestic violence), trauma, and related difficulties developing the emotion regulation, interpersonal, and self-management skills that protect against domestic violence (Capaldi, Knoble, Shortt, & Kim, 2012; Marotta, 2022). A study of men engaged in substance abuse treatment, for example, found a significant association between number of adverse childhood experiences and physical and sexual domestic violence perpetration by both Latino and White men (Gilchrist, Radcliffe, Noto, & d'Oliveira, 2017). Another research review examining adverse childhood experiences for African American men found a clear association with domestic violence perpetration that was due, at least in part, to greater alcohol use problems (Lee et al., 2022). A study of domestic violence within same-sex relationships found minority stress in the form of internalized homonegativity (i.e., internalized negative societal attitudes about one's homosexuality) was associated with greater emotion instabilty, which in turn was associated with greater physical domestic violence (Trombetta & Rollè, 2023). These studies highlight the complex interplay that occurs between distal and dynamic risk factors and the relevance of adopting a trauma-sensitive lens within domestic violence treatment (Taft, Murphy, & Creech, 2016).

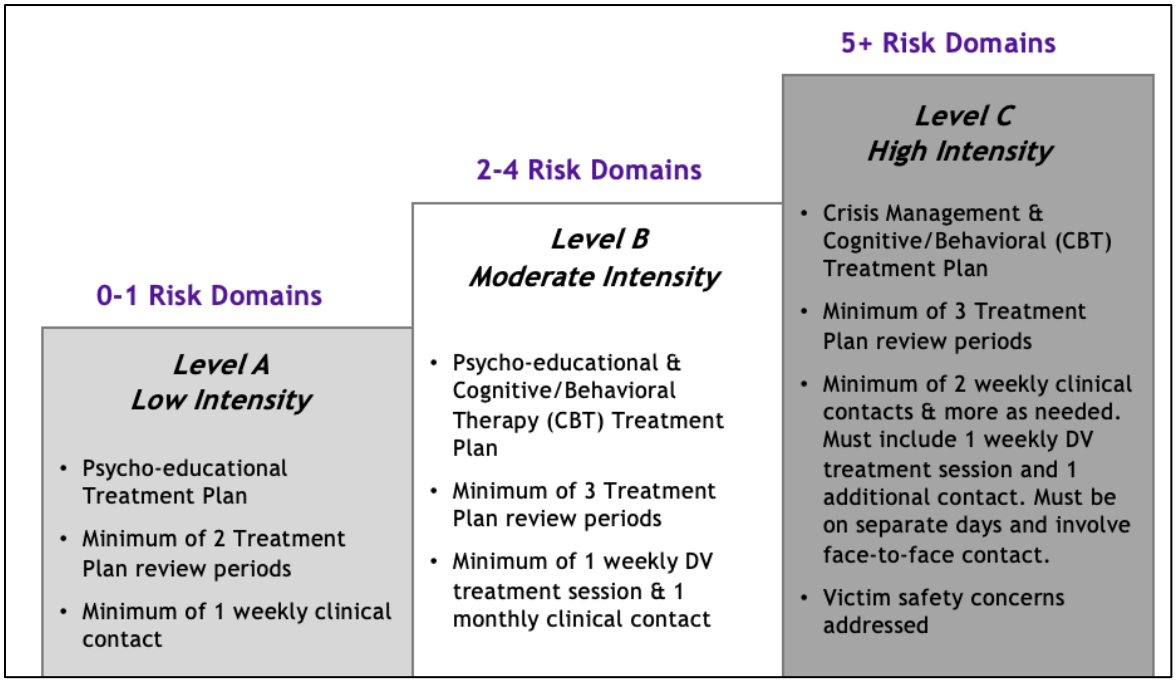
Implications of the Research Review for DVOMB Standards and Guidelines

The DVOMB was the first in the nation to develop *Standards and Guidelines* to comport with the RNR Principles. The *Standards and Guidelines were revised* in 2010 to move from the time-driven 36-week model to a risk-informed treatment approach. Integrating the RNR principles created a individualized treatment process where more importance is given to the offender meeting all of the treatment goals rather than the passage of a specific amount of time. The *Standards and Guidelines* for domestic violence treatment outline the comprehensive set of planned therapeutic goals and interventions designed to uniquely change the power and control, abusive thoughts, and behaviors that are part of domestic violence. As part of applying the RNR principles and individualizing treatment, the DVOMB also requires Approved Providers to utilize the Domestic Violence Risk and Needs Assessment (DVRNA) with each offender referred for treatment as part of a comprehensive evaluation. The DVRNA contains both static and dynamic risk factors which help identify the appropriate intensity of treatment and the specific treatment needs and goals. The DVRNA also allows Approved Providers to measure client progress in treatment in conjunction with progress on the core competencies. As part of the ongoing work of the DVOMB, the updated research review is being used to inform redesign and development of the DVRNA-Revised and revision of the treatment competencies. The intention of this is to create greater coherence between evaluation and treatment, and better reflect the empirical evidence concerning dynamic risk factors and protective factors.

Domestic Violence Risk Needs Assessment (DVRNA)

The Colorado Domestic Violence Risk and Needs Assessment (DVRNA) is a structured risk assessment used to evaluate and place domestic violent offenders into differential domestic violence treatment levels in Colorado. The standards governing the administration, scoring, and application of the DVRNA are outlined in the *Standards and Guidelines*. The DVRNA is composed of 14 risk domains (e.g., prior domestic violence-related incidents), each with a range of risk items indicative of that risk factor. It is administered and scored by DVOMB Approved Providers who have completed a full day of training on the instrument. The total DVRNA score corresponds to a recommended domestic violence treatment placement level that varies by low, moderate, or high intensity, as shown in **Figure 1**. The DVRNA operationalizes the Risk and Need principles of the RNR Model. It promotes matching treatment intensity to the risk level of the client and some of the risk domains are dynamic and reflect problems clients can seek to address and reduce through treatment.

Figure 1. DVOMB Domestic Violence Treatment Levels.



The DVRNA was initially developed in 2010 by the Treatment Review Committee of the DVOMB. The items, domains, and structure of the DVRNA were derived from a thorough review of the empirical research literature, and input from Approved Providers and DVOMB staff with extensive experience with domestic violent offenders. At the time, few other domestic violence risk instruments were available. A small validation study was conducted in 2017 found the DVRNA risk-treatment need categories were correlated with domestic violence and general recidivism. The domestic violence offenders placed in the high-risk category had higher domestic violence and general recidivism than those placed in the moderate-risk category. Too few offenders were in the low-risk category to enable them to be included in the analysis. A reliability analysis of the DVRNA was also conducted in 2021 that found adequate reliability for some domains but problems with other domains. This was largely due to low numbers of items in some risk domains and/or lack of consistency between what the items within the same domain measured.

2023 DVRNA Validation Study Highlights

The DVRNA was evaluated more extensively in 2023 to examine its predictive validity and with a view towards revising it to improve its predictive accuracy, utility for treatment planning and monitoring, and ease of use. The validation study sought to describe the DVRNA profile and recidivism rate of the sample, and examine how well the DVRNA predicted domestic violence and other recidivism.

Study Data

The study included 787 individuals who had a completed DVRNA assessment between October 2018 and August 2021, and who had provided consent to release information to allow recidivism data matching. These data were collected prior to the data collection requirement from House Bill 2022-1210 in June 2022. The data record indicated that 75% of the study group were male, 25% were female, and 1.5% identified as LGBTQ.[14] No ethnicity data was available in the data record. The mean age of the study group was 35.22 years (*SD*=10.89 years) with females being on average 2.65 years younger than males. An additional 947 individuals with DVRNA assessments for the same period did not consent to release information and were not included in the study. Comparatively, the study group was of similar age but lower risk with a mean DVRNA Total score of 4.99 (*SD*=2.17) versus 5.48 (*SD*=2.30).

The recidivism data was extracted from the Colorado ICONS and Denver County criminal justice records, and prepared for the study by the Office of Research and Statistics, Division of Criminal Justice, CDPS. The recidivism data included all charges except minor traffic or petty offenses received during the follow-up period. The follow-up period included from the date of the DVRNA assessment date to the recidivism data extraction date of November 1, 2022, with the mean follow-up length being 2 years (748 days, *SD*=161 days).

DVRNA Profile

The proportion of the study group with each DVRNA risk domain and the mean DVRNA total score are shown in **Table 2**. As shown, two-thirds of the study group had a history of prior domestic violence incidents and a non-domestic violence criminal history. Most of the study group had one or more significant items present, while over half had a critical item present. Significant and critical items indicate greater risk or potential severity of domestic violence, and correspond to a recommended minimum treatment level when present.

[14] Separate analyses for male and female gender were conducted to examine how the DVRNA performed across both genders. Females had a significantly lower domestic violent recidivism rate than males (17.6% of the domestic violence recidivists were female whereas females comprised 25% of the sample); however, the ability of the DVRNA to predict recidivism was comparable. The low number of study group members identified as LGBTQ limited the ability to examine and draw reliable conclusions about the DVRNA and recidivism in LGBTQ identifying persons. The analyses presented in this report are for the entire sample combined.

Table 2. DVRNA Total Score and Proportion with each Risk Domain (N=787).

Risk Domain	% with Risk Domain	Risk Domain	% with Risk Domain
A. Prior DV Incidents	67.9%	H. Safety Concerns	51.7%
B. Drug/Alcohol Abuse	53.7%	I. Violence Toward Family	45.9%
C. Mental Health Issues	36.7%	J. Attitudes Support DV	26.3%
D. Suicide/Homicide Concern	15.8%	K. Prior DV Tx.	26.6%
E. Weapons Concerns	30.6%	L. Victim Separated < 6 months	22.4%
F. Non-DV Crim Hx.	67.6%	M. Unemployed	22.4%
G. Obsession Victim	23.6%	N. Pro-criminal Influences	13.0%
Significant B Override Item[a]	88.6%	Critical C Override Item[b]	54.9%
Total Score (0-14)	*M*=5.0 (*SD*=2.2)		

a. 15 items on the DVRNA are identified as significant items, which when present, result in an override to a minimum of level B (moderate intensity) placement if the total score corresponds with level A placement.
b. 5 items on the DVRNA are identified as critical items, which when present, result in an override to a minimum of level C (high intensity) placement if the total score corresponds with level A or B placement.

Recidivism Rates

The rate of recidivism for the study group is shown in **Table 3**. As shown, 35% of the study group recidivated during the follow-up period, with 23% of the study group recidivating with new domestic violence-related charges.

Table 3. Recidivism (Charges) Across the Follow-Up Period (N=787).

Charge Type	Number (%) with Any Charges	Range of Total Charges	Mean (*SD*) Charges
DV-Related Violence	182 (23%)	-	-
DV Assault	133 (17%)	0-52	.78 (*2.95*)
Violation Protection Order	135 (17%)[a]	0-18	.43 (*1.52*)
Child Abuse/Assault	20 (2.5%)[b]	0-9	0.05 (*0.47*)
Any Violence	191 (24%)	-	-
DV-Related Violence	182 (23%)	0-69	1.26 (4.36)
Non-DV Related Violence	97 (12%)	0-15	0.28 (*1.06*)
Any Recidivism	278 (35%)[c]	-	-
Non-Violent	167 (21%)	0-16	0.51 (1.45)

a. 90/135 (67%) also had a DV assault charge
b. 15/20 (75%) also had a DV assault charge
c. 182/278 (65%) also had a DV-related charge

Treatment Placement Level and Recidivism

An important question concerning the predictive validity of the DVRNA is the extent the resulting treatment levels separate domestic violence offenders into groups with different risk levels. To address this, **Table 4** shows the rate of domestic violence and any recidivism by final treatment placement level. For these recidivism analyses, the *DV Recidivism* and *Any Recidivism* categories are reported.[15] As shown, the proportion of cases with domestic violence recidivism increased twofold from placement A to placement B, and again threefold from placement B to placement C. The proportion of cases with any recidivism was similar for placements A and B, but increased twofold for placement C. The differences in recidivism by placement level were statistically significant.[16]

Table 4. Placement Level for Cases with and without Recidivism (N=787).

Treatment Level	No DV Charges[a] n (%)	DV Charges[b] n (%)	No Charges[c] n (%)	Any Charges[d] n (%)
A (low intensity)	23 (96%)	1 (4%)	19 (79%)	5 (21%)
B (moderate intensity)	162 (91%)	16 (9%)	142 (80%)	36 (20%)
C (high intensity)	420 (72%)	165 (28%)	348 (60%)	237 (40%)

a. No DV Recidivism included individuals without any charges for DV-related offenses.
b. DV Recidivism included individuals with charges for DV, VPO, or Child Abuse/Assault offenses.
c. No Recidivism included individuals with no charges for any offenses.
d. Any Recidivism included individuals with one or more charges for any offenses, excluding petty crimes.

DVRNA Scores and Domestic Violence Recidivism

In addition to examining the validity of the placement level made by the DVRNA, it is also informative to examine the degree each risk domain differentiated between those offenders who recidivated in the follow-up period and those who did not. **Table 5** shows the proportion of recidivists and non-recidivists who had each risk domain present. As shown, some risk domains were present more significantly and more often in the recidivist group than in the non-recidivist group. Other risk domains did not discriminate. The Odds Ratio (OR) is an effect size measure that indicates the degree of relationship between risk domain and recidivism. In these analyses, an OR > 1 indicates the Risk Domain was associated with Domestic Violence-Recidivism and an OR < 1 indicates the Risk Domain was associated with No Domestic Violence Recidivism.

[15] Initially the study also examined non-domestic violence Violent Recidivism but such a high degree of overlap between domestic violence Recidivism and non-domestic violence Violent Recidivism categories existed that these analyses added little value.

[16] DV Charges vs. No DV Charges, $X^2(2, N=787) = 33.35$, $p<.001$, $\varphi = .206$; Any Charges vs. No Charges, $X^2(2, N=787) = 26.86$, $p<.001$, $\varphi = .185$. The results were similar when DVRNA recommended (vs. final) treatment level was analyzed.

Table 5. Presence of DVNRA Risk Domain By DV Recidivism (N=787).

Risk Domain Present	No DV Charges	DV Charges[a]	X^2	*Odds Ratio*
A. Prior DV Incidents	390 (64.5%)	144 (79.1%)	<.001	2.089*
B. Drug/Alcohol Abuse	310 (51.2%)	113 (62.1%)	<.01	1.558*
C. Mental Health Issues	219 (36.2%)	70 (38.5%)	n.s.	1.102
D. Suicide/Hom. Concern	96 (15.9%)	28 (15.4%)	n.s	.964
E. Weapons Concerns	171 (28.3%)	70 (38.5%)	<.01	1.586*
F. Non-DV Crim Hx.	377 (62.3%)	155 (85.2%)	<.001	3.472*
G. Obsession Victim	145 (24.0%)	41 (22.5%)	n.s.	.922
H. Safety Concerns	298 (49.3%)	109 (59.9%)	<.01	1.538*
I. Violence Toward Family	276 (45.6%)	85 (46.7%)	n.s.	1.045
J. Attitudes Support DV	153 (25.3%)	54 (29.7%)	n.s.	1.246
K. Prior DV Tx.	152 (25.1%)	57 (31.3%)	<.10	1.359
L. Victim Sep. <6 mths	129 (21.3%)	47 (25.8%)	n.s.	1.285
M. Unemployed	127 (21.0%)	49 (26.9%)	<.10	1.387
N. Pro-criminal Influences	53 (8.8%)	26 (14.3%)	<.05	1.736*
Total Score (0-14)	4.78 (2.18)	5.66 (2.0)	<.001	-

a. DV Recidivism includes any charges for DV, VPO, or Child Abuse/Assault offenses.
b. Fisher's Exact (1-sided) test of significance.
* 95% Confidence Interval for the Odds Ratio was significantly different than 1.
n.s. = no statistically significant difference between groups with and without DV Recidivism.

Length of Time to Domestic Violence Recidivism by Treatment Level

Cox regression survival analyses were used to examine domestic violence recidivism by treatment placement level as a function of time since the DVRNA assessment was conducted, as shown in **Figure 2**. An advantage of survival analyses is the method controls for the unequal follow-up periods among the participants in the study and shows the speed with which recidivism occurs. As shown, the domestic violent offenders in the highest risk group (Level C) both have greater domestic violence recidivism and at a faster recidivism rate.

The Reciever Operating Curve (ROC) for the DVRNA Total Score (0-14) is shown in **Figure 3**. ROCs are graphical plots that evaluate the accuracy of a risk prediction tool and are commonly used in predication validity studies. ROCs analyses produce a statistic, the Area Under the Curve (AUC), which reflects the probability that a randomly selected recidivist has a higher score than a randomly selected non-recidivist. An AUC of 0.5 (the diagonal red line) indicates the instrument is performing at chance level, while an AUC of 1.0 indicates it is performing perfectly.

Figure 2. Cox Regression Survival Functions for DV Recidivism by Placement Level.

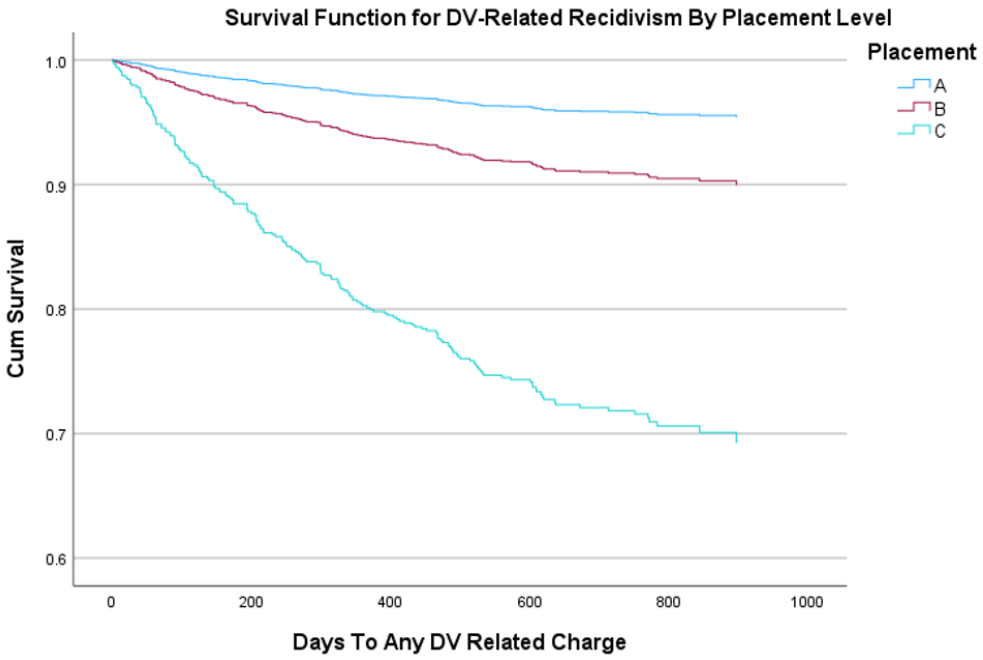
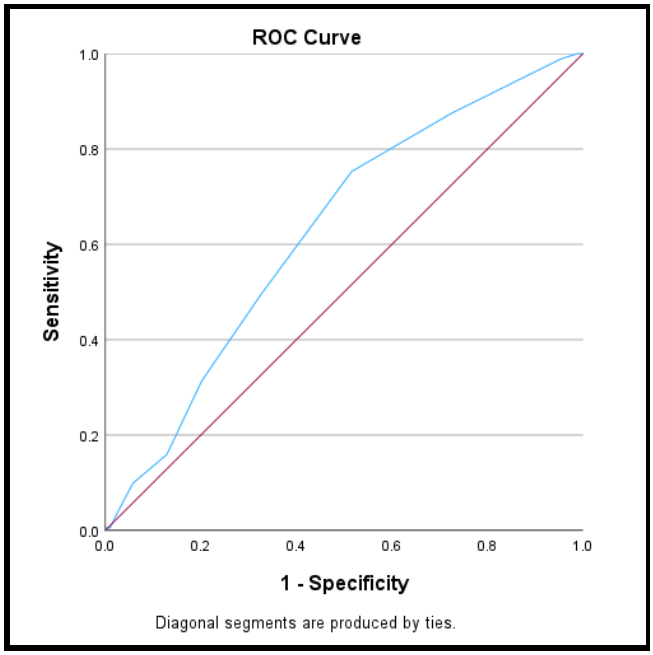


Figure 3. Receiver Operating Curve for DVRNA Total Score (0-14) and DV Recidivism.



In **Figure 3**, the AUC for the DVRNA was 0.627 ($p < .001$). This shows that it was accurately identifying a recidivist from a non-recidivist in 63 out of 100 cases. Using the common interpretive guide for risk prediction tools (Rice & Harris, 2005), the DVRNA total score had a small to moderate predictive effect. This is acceptable but also highlights potential for improving the predictive accuracy with revision of the tool.

Discussion and Implications

The current evaluation of the DVRNA builds on earlier work by involving a larger study group sample, more complete Colorado recidivism data, and a longer follow-up period. The data allowed examination of the predictive validity of the DVRNA, key findings from which were highlighted above. As seen from the DVRNA profiles for the study group, the domestic violence offenders were commonly characterized by high rates of prior domestic violence incidents, prior non-domestic violence criminal histories, substance abuse problems, and safety concerns. Over 20% of the study group had one or more new domestic violence related charge over the follow-up period (average 2 years) and 35% had at least one new offense charge (excluding minor traffic and petty offenses). The DVRNA placement level separated study group members into valid risk groups that differed by recidivism rates and examination of the DVRNA total score showed it had small to moderate predictive accuracy. Examination of the individual domain risk factors revealed some risk domains underpinned the effectiveness of the DVRNA, while others did not add significantly.

The study findings indicate the DVRNA is a valid instrument, and also highlights the potential for improvement. The findings suggest that refinement of the risk domains, and items that contribute within the domains, could create an equally or more predictive instrument that is streamlined and easier to administer. An opportunity to revise the dynamic risk factors to incorporate advancements in dynamic risk assessment and treatment planning also exists. In its present form, the DVRNA mixes dynamic and static risk factors, whereas it would be better if there were separate static and dynamic parts to the instrument as this would facilitate reassessment of dynamic risk factors across treatment. An opportunity also exists to construct the dynamic risk factor section in a way that aligns more closely with the treatment targets outlined in the *Standards and Guidelines*. Both of these proposed revisions would support evidence-based practices and strengthen integration of the RNR model into programming. Finally, a revision to the DVRNA that capitalizes on the findings of this study can also address the issues raised by the earlier reliability study.

DVOMB Data Analysis

Data Collection Overview

The Colorado Legislature passed House Bill 2022-1210 in June 2022, which mandated the DVOMB, as part of its reauthorization, 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. Shortly after the passage of the DVOMB reauthorization bill, the Board began developing plans on how to address the new statutory mandates. A proposal was presented to the DVOMB at the May 2022 meeting regarding how to address the new data collection requirement, which was subsequently approved in September of 2022.

The data collection plan offers two options for DVOMB Approved Providers to submit client-level data at discharge. The first option is to submit client level data 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 operated by a privately owned company. Approximately 78.6% of DVOMB Approved Providers are subscription customers of ReliaTrax and enter treatment program data through this

system. For this reason, ReliaTrax and the DVOMB worked together to add the new data collection requirements to their system to prevent DVOMB Approved Providers from having duplicate data entry efforts. The DVOMB held a series of trainings in conjunction with ReliaTrax between October and December of 2022 regarding the purpose of this data collection, the process for obtaining a research release from clients, and how to enter the data.

Data collection began on January 1st, 2023, and ongoing technical assistance for data collection has been offered as DVOMB Approved Providers implement this new requirement. DVOMB Approved Providers submit data for each treatment episode for each individual client. The DVOMB analyzes this data and presents findings in aggregate, and can not be used to isolate individual provider data or outcomes. The data analyzed for this report is a combination of records from both the ReliaTrax and the PDMS. Data submitted by DVOMB Approved Providers after June 30th, 2023 was omitted from this year's report in order to align with a Colorado State Fiscal Year format in out years. As a result, the data included in this report provides a baseline for future comparisons and a snapshot regarding the implementation of the data collection mandate.

Background and Sample Characteristics

From January 1st, 2023 through June 30th, 2023, a total of 437 client records were submitted by DVOMB Approved Providers, 130 of which originate from the PDMS and 307 of which originate from the ReliaTrax management system. About half of the clients (46.9%) consented to share their personal identifying information for the purposes of future recidivism tracking. **Table 6** displays demographic characteristics of clients included in the present sample.

Highlights from the demographic data include that 81% of clients identified as male and 19% of clients identified as female[17]. Further, 98% of clients with a known sexual orientation identified as Heterosexual[18]. On average, clients were 34 years old at the time of their offense, with client age ranging from 17 to 64 years. Of clients with educational information available, half reported having a high school degree or equivalent (50%).

Of the 402 clients with documented race/ethnicity, 45% self-identified as white and 38% as Hispanic. When asked to characterize their Hispanic origin, of the 271 clients with responses to this question, the majority identified that they were Not of Hispanic Origin (59%), and 31% identified that they were of Mexican origin. It is important to note that information regarding individuals who identify as mulitple racial/ethnic groups is not fully represented in this data, as Approved Providers are limited to indicating one racial/ethnic category per question.

Regarding relationships with victims, 29.1% were married/common law; 15.3% were separated; 11.7% were dating; 31.6% were in an exclusive relationship; 5.3% were in an open relationship; and 1 (.2%) was divorced.

[17] Gender Identity options available in the PDMS and Reliatrax systems include Male, Female, Intersex, Transgender Female, Transgender Male, Two-Spirit, Non-Binary, and Not Listed.

[18] Sexual orientation options available in the PDMS and Reliatrax systems include Heterosexual, Gay, Lesbian, Bisexual, Pansexual, Asexual, Questioning, and Self-Identify.

Table 6: Client Demographics. For screen reader accessible table, see Appendix A.

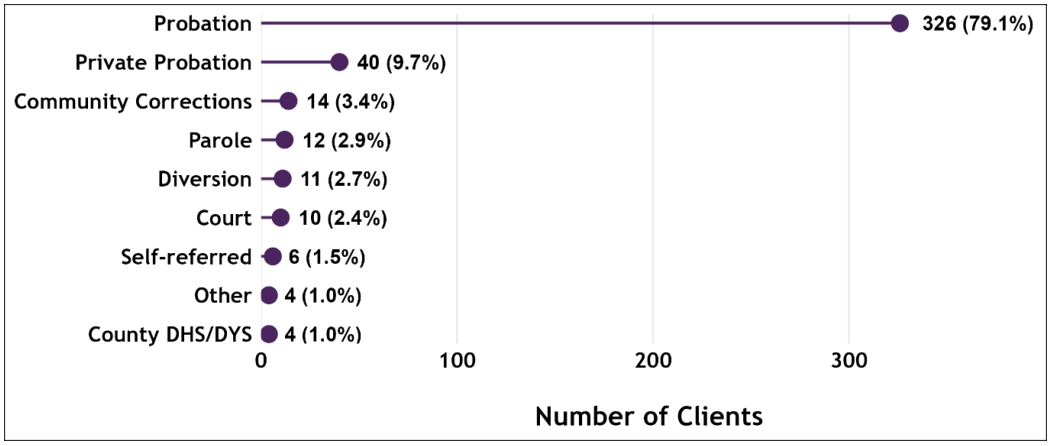
Client Characteristic (N = 437)	# of Responses	n (%) / Mean (Range)
Gender	413	
Male		336 (81%)
Female		77 (19%)
Missing		24
Sexual Orientation	410	
Heterosexual		400 (98%)
Bisexual		6 (1.5%)
Gay/Lesbian		3 (0.7%)
Self-identify		1 (0.2%)
Missing		27
Race/Ethnicity	402	
White		181 (45%)
Hispanic		154 (38%)
Black or African American		35 (8.7%)
Latino		12 (3.0%)
Native American or American Indian		11 (2.7%)
Asian or Pacific Islander		8 (2.0%)
Not listed here		1 (0.2%)
Missing		35
Hispanic Origin	271	
Not Hispanic Origin		159 (59%)
Mexican		84 (31%)
Not Listed Here		25 (9.2%)
Puerto Rican		*
Latino		*
Missing		166
Age (At Time Of Offense) Mean (Range)	410	34 (17 - 64)
Primary Language	273	
English		246 (90%)
Spanish		26 (9.5%)
Not listed here		1 (0.4%)
Missing		164
Highest Education (At Time of Offense)	271	
High school degree or equivalent (e.g., GED)		136 (50%)
Less than high school degree		51 (19%)
Bachelor degree		34 (13%)
Vocational schooling		19 (7.0%)
Associate degree		13 (4.8%)
Some college but no degree		13 (4.8%)
Graduate degree		5 (1.8%)
Missing		166

Missing data is shown but not calculated in the overall percentages.
*Data suppressed to maintain client confidentiality

Clients in the present sample represent 16 of the 23 Judicial Districts in Colorado. Arapahoe, Boulder and Weld counties constituted the majority of records submitted during this six-month period. However, it is projected that the Judicial Districts not represented are still in the process of implementing the data collection requirement or have not yet submitted any data. The program staff are working with jurisdictions and Approved Providers to identify and address any existing barriers to reporting information.

Prior to the start of domestic violence offender treatment, records submitted by DVOMB Approved Providers indicated 20 clients (4.6%) were sentenced to unsupervised probation and 154 clients (35.2%) had a protection order that was modified prior to the start of domestic violence offender treatment. As displayed in **Figure 4**, most clients were referred from Probation (76%) or Private Probation (9.4%).

Figure 4: Number of Domestic Violence Treatment Clients by Referral Source (n = 412)*.
See Appendix A for chart data table.



*Percents do not add up to 100 % as more than one referral source may be selected for each treatment client.

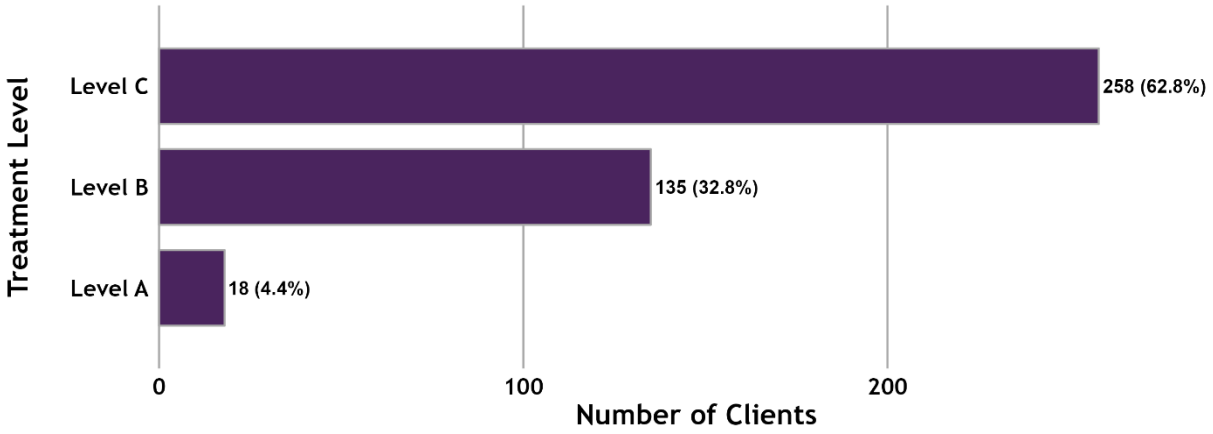
Assessment and Evaluation Variables

From the point of referral, 389 (89%) clients had an evaluation completed within 30 days from the time the DVOMB Approved Provider was notified the client was being referred to treatment. Approved Providers reported using the following types of documents during the evaluation process (providers can select multiple document types):

- Law Enforcement Summary Reports (91%)
- Criminal History (71%)
- Victim Statements (25.9%)
- Substance Abuse Evaluations (9.8%)
- Domestic Violence Offender Evaluations (9.2%)
- Mental Health Records (5.9%)
- Other Documents (4.3%)

The DVRNA presents a framework created by the DVOMB within which to assess the risk of future intimate partner violence for domestic violence offenders in treatment. For details, please see the previous section on the DVRNA validation study. As shown in **Figure 5** below, over half of clients were both recommended and placed in Level C high intensity treatment. This figure excludes 28 records where either treatment level recommended or treatment level placed were unknown.

Figure 5: Distribution of Treatment Levels Placed for Colorado DV Treatment Clients (n = 411). See Appendix A for chart data table.



Based on the results of DVRNA as part of the offender evaluation, the DVOMB Approved Provider consults with the Mulit-Disciplinary Treatment Team (MTT) to confirm the placement of the client in a treatment level. The MTT consists of the DVOMB Approved Provider, the supervising agent, and a treatment victim advocate. The MTT is designed to collaborate and coordinate offender treatment which includes staffing cases, sharing information, and making informed decisions related to risk assessment, treatment, behavioral monitoring, and the management of offenders while in treatment. The majority (80.1%) of clients remained in the same treatment level throughout the course of their treatment. Treatment levels decreased for 49 (11.2%) of clients, and increased for 9 (2.1%) of clients.

In terms of the second contact recommendations, 35% of the clients were referred for mental health treatment, 35% were referred for an unspecified second contact, 34% were referred for substance abuse contacts, 11% for Moral Reconation Therapy (MRT), and 1 client for Eye Movement Desensitization and Reprocessing (EMDR).

Responsivity Factors

In terms of responsivity factors[19], 62.5% of Approved Providers identified the therapeutic alliance; 67% incorporated client feedback; 48.7% identified collateral contacts; and 39.1% identified the topic of treatment sessions; and 1.8% identified other factors.

Approved Providers identified the following barriers during treatment:

- Finances (28%)
- Client Factors (20%)
- Employment Factors (9%)
- Lack of Social Supports (7%)
- Cultural Needs (5%)
- Transportation (3.4%)

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

- Housing Issues (3.2%)
- Adjunct Treatment Needs (3%)
- Lack of Engagement with the Community (2.7%)
- Terms of Supervisions (2.1%)
- Community Limitations (1.6%)
- Lack of Specific Resources (1.1%)
- Other (5.3%)

In terms of responsivity factors, DVOMB Approved Providers reported addressing clients' needs by:

- Offering Vouchers (21%)
- Adjusting Treatment (9%)
- Adjusting Treatment Language (8.5%)
- Adjusting Treatment Modalities (8%)
- Using External Supports (6%)
- Considering Culture Factors (5%)
- Using Specialized Resources (4.8%)
- Providing Housing and Transportation Support (0.5%)
- Using Other Supports (1.4%)

Treatment Absences

Consistent attendance in treatment sessions is critical to providing structure and ensuring clients address the treatment areas needed to effectively reduce their risk. The data indicated 12.6% of clients did not miss any treatment sessions; 32% missed 1-3 times; and a majority of clients (48.7%) missed 4 or more times. Note, 6.6% of clients did not have a response for this question. Excessive absences can serve as a barrier for clients to effectively engage in the treatment process. While the *Standards and Guidelines*[20] provide allowances for excused absences, excessive absences have been anecdotally reported as a problem for continuity and often led to early terminations from treatment.

Treatment Modalities

In terms of treatment modalities, 55% of clients received group therapy, 12.8% received individual sessions, 43.5% received teletherapy group, 14.9% had individual teletherapy, and 0.2% had teletherapy for medical or weather-related emergencies. Note, more than one treatment modality could be used for each client.

Further, 54.2% of clients received In-person sessions only (group or individual sessions), 34.3% received Teletherapy Only (teletherapy group, individual teletherapy, or teletherapy for medical or weather-related emergencies), and 11.5% received mixed modes of both in-person and teletherapy.

[20] If an offender has more than three absences, the MTT shall consult to determine any needed consequences or modifications to the Treatment Plan. The MTT may require the offender to provide documentation of reasons for absences. All offender absences shall be reported within 24 hours of the absence to the Treatment Victim Advocate and the referring agency.

Treatment Outcomes

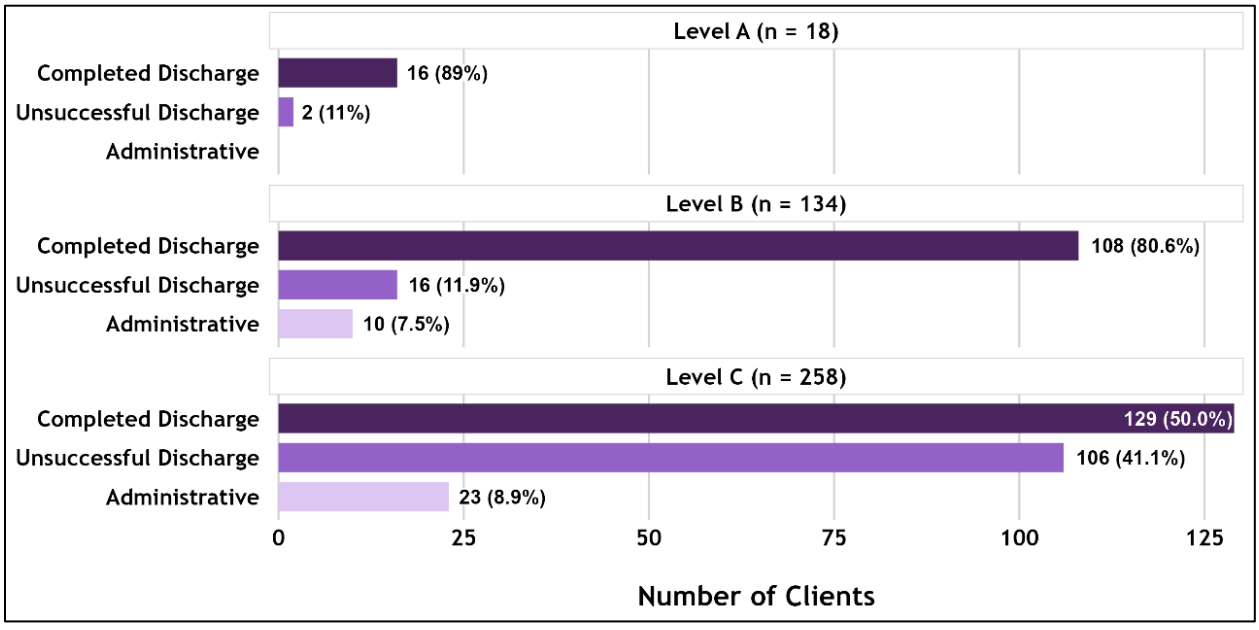
The *Standards and Guidelines* require the MTT to reach consensus regarding the client discharge, based on criteria being met by the client over the course of treatment. A client who receives a completed discharge indicates that the MTT has verified that the client:

- Has progressed and addressed the core competencies
- Has completed the required minimum number of treatment plan reviews
- Has no additional risk factors
- Has met the requirements and conditions of their treatment plan.

A client who receives an unsuccessful discharge indicates that the MTT agrees that the client lacked progress related to the core competencies, the client had compliance issues with the offender contract or treatment plan, or the client was engaging in risk-related behaviors. In the event a client has circumstances arise beyond their control, the MTT can administratively discharge a client. Reasons for an administrative discharge include instances where the client relocates due to changes to their employment, the client is ordered to deploy as part of their military service, a medical condition prevents their participation in treatment, or there is another clinical reason for a transfer to a different DVOMB Approved Provider.

Among 411 clients with discharge outcome information reported, 62% had Completed discharges, 30% had Unsuccessful discharges, and 8.0% had Administrative discharges. As displayed in **Figure 6**, rates of successful treatment completion increase as the corresponding risk decreased by treatment level. Clients in treatment level A had the highest percent of successfully completed discharges (89%). Clients in treatment level C had the lowest completed discharge rates at 50%. The substantial difference in successful treatment completion rates seen in Level C clients are likely influenced by the underlying higher risk levels of clients assigned to this level of treatment. This is congruent with the research indicating higher risk individuals are more challenging to retain and complete in treatment.

Figure 6: Discharge Outcomes by Treatment Level Placed for Colorado DV Treatment Clients (n = 410). See Appendix A for chart data table.



Approved Providers are required to indicate at least one discharge reason for each treatment client, regardless of treatment outcome. **Table 7** presents the discharge reasons indicated for clients with Unsuccessful Discharge types. The largest specified category (excluding "Other") of discharge reasons was Excessive Absences, which was indicated for 25% of clients. Of note, 7 Approved Providers reported their clients had a Violation of Treatment Plan/Contract, and 7 reported New Domestic Violence Related Offenses.

Table 7: Discharge Reasons for Colorado DV Treatment Clients With Unsuccessful Discharges

Discharge Reason (n = 125)	Number of Clients (%)
Administrative - Other	61 (49.0%)
Unsuccessful - Excessive Absences	31 (25.0%)
Unsuccessful - Dropped out of Program/Abandoned Treatment	8 (6.0%)
Unsuccessful - Violation of Treatment Plan/Contract	7 (6.0%)
Unsuccessful - New domestic violence related offense	6 (5.0%)
Unsuccessful - Non-Compliance with Monitored Sobriety/Drug Alcohol Use	5 (4.0%)
Unsuccessful - Other	5 (4.0%)
Unsuccessful - Never Attended/Failed to Begin Program	3 (2.0%)
Unsuccessful in Progressing with Core Competencies	1 (1.0%)

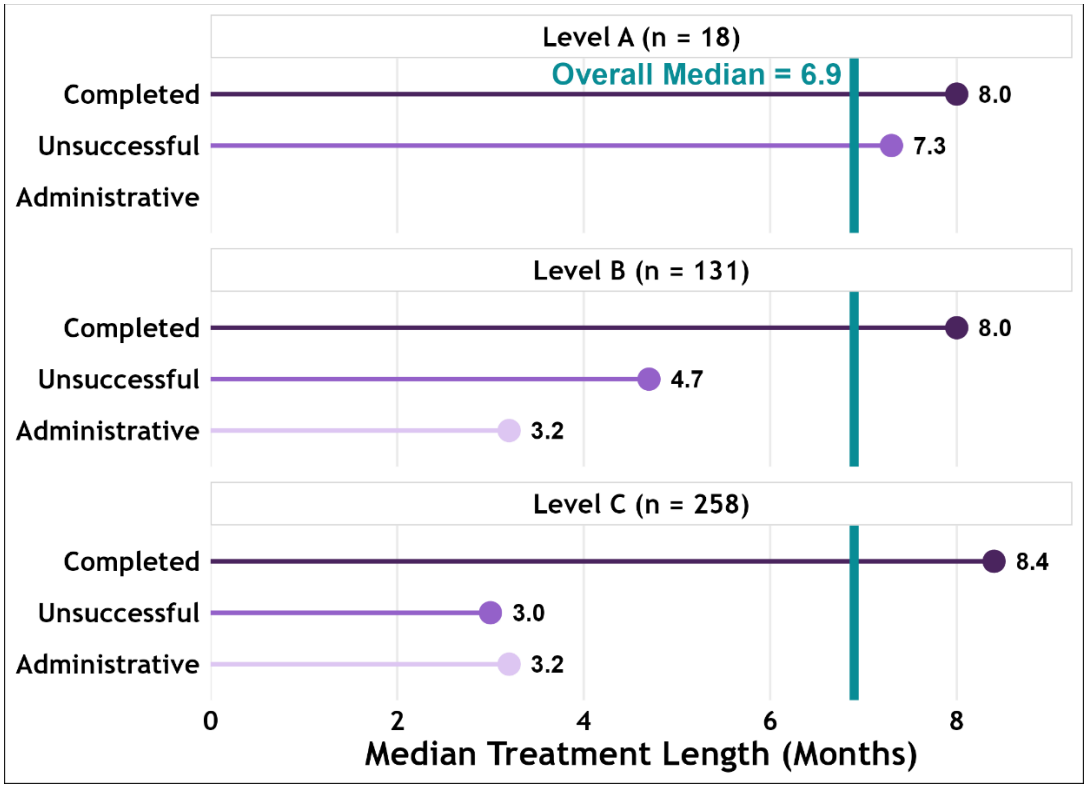
Treatment Duration

Treatment duration ranged from 0 to 34.6 months (2.88 years). The median duration in treatment was 6.9 months across all discharge types. **Figure 7** below displays the median treatment length by treatment level. Looking across all discharge types, the median treatment length for clients who are discharge unsuccessfully was 3.0 (SD = 5.6). Level C clients (n = 258) who completed treatment had the highest median treatment length at 8.4 months and conversely the shortest average treatment duration of 3.0 months for those who discharged unsuccessfully. Attributing these differences in length of stay is principally due to the clients relative risk level as higher risk clients (Level C) are less likely to complete treatment and discharge early. This result is not suprising given that the risk profile and characteristics associated Level C clients as measured by the factors of the DVNRA. This result is consistent with research suggesting that higher risk clients (i.e., those in treatment level C) require a higher dosage and intensity of treatment to address co-occuring issues as mandated by the Standards.

Limitations

There are several limitations to the DVOMB Data Analysis as part of the new data collection mandate in the present sample. This data only represents approximately six months worth of preliminary data from January 1st through June 30th of 2023 and is limited to 16 of the 23 Judicial Districts. The implementation of the mandated requirement to submit data is still ongoing with room for improvements regarding missing data and the client rate for agreeing to the research release. As a result, the DVOMB Data Analysis included in this report provides a baseline for future comparisons and a snapshot regarding the implementation of the data collection mandate. The results in the DVOMB Data Analysis should not be generalized until more data is collected in out years. DVOMB program staff will continue offering training and technical assistance to resolve missing data issues as part of the implementation process.

Figure 7: Treatment Length for Colorado DV Treatment Clients by Treatment Level Placed (n = 408). See Appendix A for chart data table.



Summary and Conclusions

All active DVOMB Approved Providers have been trained and are now submitting data to the DVOMB. The DVOMB has received a significant amount of data in the present sample, which demonstrates commitment on the part of many Approved Providers to support evidence-based research for the *Standards and Guidelines*, as well as fidelity in implementing them. Data included in this report provides a baseline for future comparisons and a snapshot regarding the implementation of the data collection mandate. The PDMS will also provide an avenue for DVOMB Approved Providers to track service provision, communicate issues and concerns, and share what is working directly to the DVOMB. The data collection system includes comment boxes throughout the process which allows Approved Providers to input comments and other qualitative data. The DVOMB will be able to use this data to make adjustments to *Standards and Guidelines*, improve implementation processes, and provide training and technical assistance opportunities.

The *Standards and Guidelines* have set forth a differentiated treatment model based on the principles of Risk, Need, Responsivity. Based on the limited data from the present sample, Approved Providers appear to be following the *Standards and Guidelines*. It is hoped that the more clients will be represented in out years as full implementation is reached. This will serve as the foundation to further revise the *Standards and Guidelines* with evidence in supporting future policy initiatives. The PDMS and the research capabilities of the data being collected are unlike any in the United States and may help advance meaningful changes relate to policies and practices in treatment and management of domestic violence offenders going forward.

Section 2: Relevant Policy Issues and Recommendations

Background

Pursuant to HB22-1210, 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 necessarily reflect the recommendations of the Department of Public Safety.

Issues related to Cannabis Use with Domestic Violence Offenders

In 2015, the Colorado legislature passed HB16-1359 concerning the determination by a court for an individual's possession and use of medical marijuana while on probation. The bill shifted away from an assessment of the individual on probation to require the court to base its decision on any material evidence. The rule became the focus in a Colorado Supreme Court case, Walton v. People, where the higher court ruled that the presiding court must make specific findings, based on material evidence, that "prohibiting this defendant's otherwise-authorized medical marijuana use is necessary and appropriate to promote statutory sentencing goals". The case is likely the first of many as this legislation places greater emphasis on the prosecution to prove any material evidence and broad discretion to judges to apply and interpret the material evidence rule.

Walton v. People was not a domestic violence case; however, its precedent as case law has implications to the rehabilitation and treatment of domestic violence offenders. Substance misuse either through the use of illegal substances or the illegal misuse of prescribed substances is well-established in the literature as a co-occurring problem for offenders engaging in domestic violence behaviors. The link between domestic violence and substance use is established for the use of alcohol (Langenderfer, 2013), illicit drugs (Choenni, Hammink, & van de Mheen, 2017), substance use on the same-day of the abuse (de Bruijn & Graaf, 2016) or as part of ongoing dependence (Stuart et al., 2009), and transcend nearly every culture, class, region, and country (Duvvury, Callan, Carney, & Raghavendra, 2013; Eng, Li, Mulsow, & Fischer, 2010). This link can be found across samples with justice-involved and non-justice involved populations. While cannabis use has historically and culturally been perceived as a safer alternative over other substances due to being associated with mild euphoric states, relaxation, less aggression, and violence, emerging research related to intimate partner violence is challenging this notion. In a recent meta-analysis examining the relationship between substance use and domestic violence it was found "that the strength of the link between marijuana use and perpetration or victimization is on par with substances more typically associated with IPV, such as alcohol, cocaine, or amphetamines" (Cafferky et al., 2018, pg. 119).

Numerous studies have found cannabis use to be linked with domestic violence. For example, three meta-analyses reported that cannabis use was positively associated with partner violence (Cafferky et al., 2018; Moore et al., 2008; Testa & Brown, 2015). Specifically, Testa and Brown (2015) looked across 14 studies at the association between cannabis and intimate partner violence perpetration finding positive associations between marijuana use and physical (d = .21) and psychological (d = .35) intimate partner violence.[21] They noted that the frequency of cannabis use in the past year demonstrated a modest, but positive, association with the frequency of reports of intimate partner violence in the past year. As the acute effects of cannabis did not emerge as predictive of intimate partner violence, this suggests the association may be attributable to withdrawal symptoms (e.g., anxiety, irritability, and disinhibition) or because it was used in conjunction with other substances (Smith et al., 2013).

It is important to note that domestic violence is not caused as a result of substance use or misuse. Rather substances can facilitate or exacerbate an offender's other risk-related propensities, such as attitudes and behaviors that are rooted in a belief system supportive of domestic violence. However, untangling the causal mechanisms linking cannabis use and intimate partner violence is complex and not yet fully understood. Much of the earlier literature examining the relationship between cannabis and domestic violence failed to control for known risk factors related to intimate partner violence that could also independently account for the link, or failed to establish the direction of the causal relationship. More recent research is addressing this limitation. Shorey et al. (2018), for example, conducted a study involving 269 men referred to batterer intervention programs that included measurement of other risk factors. Nearly 60% of their sample reported cannabis use in the previous year with nearly 40% of the sample using cannabis at least weekly. Overall, their findings suggest "marijuana use was positively and significantly associated with psychological, physical, and sexual IPV perpetration, even after controlling for alcohol use and problems, antisocial personality symptoms, and relationship satisfaction" (pg. 113).

An interesting finding was that cannabis use and alcohol use were also positively and significantly related to antisocial personality symptoms, which suggests individuals with problematic cannabis use may have a cluster of known risk factors for intimate partner violence. More recently, findings from Flanagan et al. (2020) showed "that greater quantity and frequency of cannabis use was significantly associated with greater physical IPV perpetration and victimization, after controlling for age, sex, race, and quantity and frequency alcohol and stimulant use" (pg. 327).

Trends towards legalization of medical marijuana and recreational marijuana highlight the need to evaluate such changes from both a public safety and public health lens. Since cannabis has been decriminalized in many jurisdictions including in Colorado, the commercialization of cannabis as an industry has led to increasingly higher concentrations of THC, often referred to as high-potency THC. Cannabis is considered high-potency when the concentration of THC is greater than 15%. Research has demonstrated that the medicinal benefits of THC are optimized when THC concentration is less than 10% (Romero-Sandoval et al., 2018). However, in a recent report, high-potency THC dominated the market share of cannabis in Colorado dispensaries overwhelmingly with concentrations greater than 15% (Elsohly et al., 2016). The availability of high-potency THC products to consumers can lead to serious problems related to addiction, psychosis, depression, anxiety, suicide, and violence (Dellazizzo, Potvin, Athanassiou, & Dumais, 2020). For example, research has documented the use of high-potency THC to increase the risk of psychosis threefold, with daily use increasing the risk fivefold (DiForti et

[21] "d" indicates Cohen's effect size statistic and shows the difference in rate of intimate partner violence between the group of individuals using cannabis and those not using cannabis.

al., 2019). While the research to-date does not support a strong relationship between the acute use of cannabis and domestic violence in general, "the acute effects of administration also appear to change as use becomes more severe and cannabis use disorders develop and as individuals become more susceptible to cannabis withdrawal" (pg. 328). Of note, the acute effects of cannabis intoxication may have a more deleterious effect when coupled with other vulnerabilities such as serious mental disorder (Dellazzazio et al., 2020).

Pursuant to § 18-6-801 C.R.S., individuals convicted of domestic violence are required to undergo an evaluation and treatment as recommended that complies with the *DVOMB Standards and Guidelines for the evaluation, assessment, treatment, and monitoring of domestic violence offenders*. The *Standards and Guidelines* require a comprehensive evaluation that includes a validated substance use screening assessment. Based on the findings from the evaluation, a DVOMB Approved Provider can identify substance abuse treatment as an adjunct part of the offender's treatment plan. Additionally, the *Standards and Guidelines* require offenders to agree to not abuse substances while in treatment and are subject to monitored sobriety. Thus, the rehabilitation process for an offender is undermined when a substance use issue is assessed by a DVOMB Approved Provider and the court has not found any material evidence prohibiting the offender from using cannabis. In such cases, DVOMB Approved Providers will offer the offender a choice to either cease using those substances or refer them to another DVOMB Approved Provider. The key rationale for this is that cannabis use while in treatment is associated with poorer short-term outcomes (Subbaraman, Metrik, Patterson, & Swift, 2017), at least in part because offenders using substances struggle to externalize and apply what is learned in treatment due to the related impairment in neurocognitive functioning (Dellazzazio et al., 2020).

Recommendation

The prevailing research suggesting that cannabis use may contribute to domestic violence appears contradictory to mainstream perceptions of the public. While there is some research to suggest that the decriminalization of cannabis has led to reductions in domestic violence assaults and the seriousness of those assaults (Kaplan & Sian Goh, 2022; Reed, 2021), it appears there may be some individuals who may be more susceptible to problems related to misuse in the context of domestic violence. Broadly speaking, someone who engages in domestic violence behaviors and is convicted by the criminal legal system may have a greater propensity for aggression, history of violence, or antisocial personality traits. There is sufficient evidence now that links cannabis with domestic violence across a variety of samples. It is based on the research and literature to date that the DVOMB recommends that the legislative statutorily require the DVOMB to conduct a study examining how the use of cannabis by domestic violence offenders is associated with domestic violence offender treatment participation, compliance, outcomes, and victim safety.

Public Safety Considerations and Policy Implications with Restorative Justice in Domestic Violence Cases

The following section provides a summary[22] of the key considerations and issues related to allowing cases of adult domestic violence, as defined in § 18-6-803, C.R.S., to be referred to Restorative Justice (RJ) programs. Currently, there are three provisions in Colorado law that prohibit the use of RJ with sexual assault and domestic violence cases for both adults and juveniles: C.R.S. 18-1.3-104(1)(b.5)(I),

[22] 2020 Public Safety Considerations & Policy Implications with Restorative Justice Domestic Violence Cases

18-1.3-204(2)(a)(III.5), 19-2-907(1)(l), and 19-2-925(2)(l). The Colorado Revised Statutes consistently, repeatedly, and clearly indicate prohibitions to the use of RJ in domestic violence cases, stalking cases and with violations of a protection order. RJ originated in Native American communities and has been applied widely to juveniles who have caused harm, and has had positive outcomes in non-person centered crimes (Flesher, E., 2005).

Background and Literature Review

While there is no singular profile of someone who commits domestic violence, this crime represents a wide range of acts and behaviors that can have lasting physical, emotional, financial, and psychological harm to victims (Tjaden & Thoennes, 2000). A recent analysis of the Colorado court data by the Colorado Division of Criminal Justice's Office of Research and Statistics found an annual average of approximately 17,000 cases filed and flagged as domestic violence between Fiscal Year 2009 and 2014 (Flick & English, 2016). This analysis did not include municipal data, which suggests that filings for domestic violence cases are even more pervasive in the criminal justice system. When compared to the general offending population, domestic violence offenders have been found to possess more criminogenic needs (Hilton & Radatz, 2018) and recidivate at a higher rate (Flick & English, 2016; Gondolf, 1997, 2003). The risk for re-offense and for lethality vary based on a myriad of factors and, more often than not, the crime of conviction is not indicative of an offender's risk for future recidivism.

The available research documenting RJ with domestic violence is minimal and the research that does exist mostly focuses on other areas of crime that do not have the same dynamics and concerns of domestic violence offenses. RJ has strong empirical support for property and non-violent person crimes; however, its efficacy on domestic violence offenses has yet to be strongly supported in research. There are some studies that look at RJ in tandem with other domestic violence interventions, but there are concerns with the designs and the strength of these studies as it relates to the RJ portions of the research. The RJ field of research is still beginning to grow and take traction, which warrants monitoring new studies on the topic; however, at this time there is not enough strong research to support the use of RJ practices with domestic violence offenses.

Key Considerations

Restorative Justice Practitioners and Practice Lack Regulatory Oversight

Due to the nature and seriousness of domestic violence, professionals who work with domestic violence offenders require training, competencies, and expertise in domestic violence offender dynamics and victim safety. RJ Practitioners are not regulated by any government agency or non-profit organization. There are no requirements presently for training, background checks, or supervision prior to becoming an RJ Practitioner. This means that RJ Practitioners would be unaware of the full spectrum and dynamics involved with intimate partner violence, along with risks of harm and even death to the victim[23]. DVOMB Approved Providers are trained in assessing risk of re-offense and lethality with domestic violence offenders. The initial evaluation process is extensive and requires a Multidisciplinary Treatment Team (MTT) approach. The offender is then continuously assessed throughout treatment,

[23] According to the 2020 Annual Report by the Colorado Domestic Violence Fatality Review Board, "in 2019, Colorado had at least 60 incidents where domestic violence resulted in a fatality, and 70 people died in these incidents (pg 4).

and the MTT consistently monitors the offender's progress, or lack thereof, and prioritizes victim safety.

Furthermore, there are no parameters guiding who may or may not be eligible for becoming an RJ Practitioner, including criminal history. This means that current or former domestic violence offenders, who may or may not have undergone treatment, could act as an RJ Practitioner or Facilitator. Allowing anyone to become an RJ Practitioner to work with offenders and victims of domestic violence circumvents many of the protections established by the DVOMB and represents undue risks to victims that would not be monitored if allowed, and at worst in a domestic violence setting, serious harm or loss of life.

Prohibition Against Couples Counseling

Couples counseling is not a component of domestic violence offender treatment and Section 5.10 of the DVOMB Standards and Guidelines prohibits the offender from engaging in any form of couples counseling. The offender is the client while in offender treatment, not the couple, and not the relationship. The offender is prohibited from participating in any couples counseling while in offender treatment. This includes any joint counseling that involves the offender and the victim. Because of the potential therapeutic challenges of concurrent treatment along with dangers and risk to victim safety, this Standard further clarifies that offenders will not participate in marriage or couple's counseling of any kind with anyone with the victim outside of offender treatment.

Ethical and Practice Related Concerns regarding Victim Safety

The DVOMB was created in 2000 for the purpose of standardizing the evaluation, treatment, and continued monitoring of domestic violence offenders at each stage of the criminal justice system so that such offenders will be less likely to offend again and the protection of victims and potential victims will be enhanced. Over the past two decades, the DVOMB *Standards and Guidelines* have advanced with research and use a coordinated community response to domestic violence offenders that is inclusive of the criminal legal system, service providers, non-profit victim services, and the local community. RJ practices offered to domestic violence offenders and victims may reintroduce inconsistencies in the services for offenders and increase the violence and abuse toward victims and secondary victims unintentionally.

Within the dynamics of domestic violence, the offender controls the victim through dominance, dependence, dissonance, surveillance, violence as a method of coercion and threats to force the victim into doing whatever it takes to lessen the consequences for themselves; both within the home, within family and friends, and in the legal system (Klein, 2009). This is attributable to the coercion by the offender to control the choices of the victim, which can include recanting as the victim witness, assuming blame for the offender's behaviors, and justifying the offender's behavior. The presumption that victims of domestic violence are able to willingly choose to agree to an RJ intervention is misleading and fails to account for the surreptitious manipulation and coercion by the offender. The offender may seek retribution in the form of violence and abuse that is not disclosed or known to an RJ professional or facilitator which can be dangerous to the victim.

Recommendation

In summary, RJ is an appropriate and effective intervention for many types of crimes. However, when it comes to domestic violence, there are prevailing concerns. High-quality, quantitative research examining RJ with domestic violence is limited and the available research regarding domestic violence offender treatment has yet to identify RJ as an evidence-based practice or as a promising practice. Other scholars have called into question the degree to which RJ practices can provide the necessary safeguards to not compromise a victim's safety and right to self-determination. The research supporting the use of RJ with domestic violence cases relies on anecdotal and at best, cross-sectional studies; some of which have not been peer-reviewed. As a result, the methodological weaknesses of the literature to date do not allow for a strong positive conclusion.

From a practical and victim safety perspective, domestic violence does not stem from a failing relationship. Domestic violence is the result of a pattern of coercive control removing a victim's freedom, degrading their dignity, and creating conditions that place blame on the victim. By failing to build a response around these underlying dynamics of intimate partner violence, it gives a way for a RJ program to potentially cause further harm and re-traumatize victims. Victims being presented with the option of RJ may be unknowingly coerced, forced, or otherwise manipulated by an offender to agree. Additionally, victims may be blamed for causing the abuse that was perpetrated against them and may not be open and honest out of a fear the offender will retaliate. Present research supports that this dynamic leads to these unintended consequences regarding couples counseling. Even with trained mental health professionals who are supported by parole or probation officers, it can be difficult to hold domestic violence offenders accountable in treatment and to safely manage and monitor the offender through the treatment process. In fact, this is the reason that throughout the United States where domestic violence treatment is regulated, "68% of states prohibit the use of couples treatment of any kind either before or concurrent with a primary domestic violence intervention" (Babcock et al., 2016, pg. 421).

Finally, RJ Practitioners are not regulated in the State of Colorado and there are no requirements presently for training. This means that RJ Practitioners would be unaware of the dynamics of domestic violence and risks such as lethality. Furthermore, there are no restrictions regarding who can become an RJ Practitioner. This means that current or former offenders, who may or may not have undergone treatment or who may even be abusing their partner could act as an RJ Practitioner or Facilitator.

In conclusion, it is recommended that further data and research that examine the effects and implications of RJ Programs prior to the adoption and implementation of broad policies or statutory changes regarding RJ Programs for domestic violence offenders.

Section 3: Milestones and Achievements

Overview of FY2022-2023 Accomplishments

Over the last year, the DVOMB has worked incredibly hard at revising the DVOMB *Standards and Guidelines* while reconnecting with communities across Colorado. The DVOMB was able to host its first annual conference to over 500 stakeholders. While a number of DVOMB Approved Providers have chosen to leave the field, there were 74 applications for placement or continued placement on the DVOMB Approved Provider List. As of July 2023, there were 153 active DVOMB Approved Providers of which 111 are approved to work with female offenders and 44 are approved to work with LGBTQ+ offenders. The DVOMB, in conjunction with the Sex Offender Management Board (SOMB), studied the characteristics that attract potential and current providers to the field identified in the formative research conducted with Orange Circle Consulting. This effort is to create a communication and recruitment strategy to increase the number of DVOMB Approved Providers across Colorado with specific focus on diversity, equity, and inclusion. The DVOMB hosted 38 trainings that were attended by more than 1,400 professionals on a variety of subjects related to the treatment and supervision of domestic violence offenders. Program staff also hosted monthly technical assistance hours for DVOMB Approved Providers to consult on problematic cases and ask questions related to implementing new requirements. Continued efforts were made to revise and update the *DVOMB Standards and Guidelines* through the six active committees. The DVOMB also validated the Colorado Domestic Violence Risk and Needs Assessment that is used as part of the offender evaluation to determine the treatment level needed for offenders. The validation of this assessment tool represents the culmination of nearly seven years in the making. The DVOMB also focused on issues of Equity, Diversity, and Inclusion (EDI). Finally, the DVOMB began implementing the required mandates associated with HB22-1210, specifically regarding data collection of client outcomes.

Implementation of Reauthorization HB2022-1210 Requirements

Following the Sunset Review by the Colorado Department of Regulatory Agencies (DORA) in 2022, the DVOMB was reauthorized in House Bill 22-1210 for 5 years, until 2027. 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 reauthorization bill specified that the DVOMB was required to:

- Develop a data collection plan and require DVOMB 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, prepare and present a written report to the House of Representatives Judiciary Committee and the Senate Judiciary Committee, or their successor committees, and

- Perform compliance reviews on at least 10% of DVOMB Approved Providers every two years beginning no later than July 1st, 2023.

With regard to the data collection plan, the DVOMB developed and approved a plan in the latter part of 2022 to meet the data collection requirement in the reauthorization bill. The data collection plan offers two options for DVOMB Approved Providers to submit client-level data at discharge. The first option is to submit client level data 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 is to submit data through ReliaTrax, which is an electronic health record system that is operated by a privately owned company. Approximately 78.6% of DVOMB Approved Providers are subscription customers of ReliaTrax and enter treatment program data through this system. For this reason, ReliaTrax and the DVOMB worked together to add the new data collection requirements to their system to prevent DVOMB Approved Providers from having duplicate data entry efforts.

The PDMS and ReliaTrax data collection systems became operational on January 1st, 2023. DVOMB Approved Providers received training, prior to implementation, on the purpose of this data collection, the process for obtaining a research release from the clients, and how to enter the data. Ongoing training and technical assistance have been provided regularly to DVOMB Approved Providers throughout 2023. Section One of this report includes a summary of aggregate data from the PDMS and Reliatrax data collection from January 2023 to end FY 2022-23.

With regard to the written annual report, the current 2024 DVOMB Annual Legislative Report is the second of such reports prepared and presented to the House and Senate Judiciary Committees. The report addresses each of the criteria stipulated in House Bill 22-1210 in the relevant sections of the report.

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, DVOMB 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 build upon and prioritize discussions on diversity, equity, and inclusion (DEI) within the DVOMB and provider community. The efforts centered on ensuring the *Standards and Guidelines* explicitly address DEI and developing the provider workforce to better meet DEI needs of the clients. The DVOMB also continued efforts to increase DEI in the composition and representation of those serving on the Board as well as at the committee level. A range of trainings offered to DVOMB Approved Providers and stakeholders addressed racial-ethnic cultural responsiveness and LGBTQ+ issues. For example, a full-day workshop was provided that addressed understanding and working with racial and generational trauma for BIPOC Clients. As well, guest talks at DVOMB monthly meetings included a presentation by the Asian Pacific Development Center Collaborative Language Services and a presentation on best practices for sexuality and gender diverse populations. The ODVSOM Annual Conference in July 2023 provided a keynote address on a culturally responsive framework for all, while individual sessions included presentations on missing and murdered indigenous relatives, an examination of violence against Native American women, culturally responsive care in DVOMB work, cultural diversity and culturally responsive practice, and the intersection of gender inclusive care with

transgender youth. The goal of offering these training topics and opportunities is to improve the DVOMB and affiliated stakeholders understanding of, and capacity to respond to, issues of Diversity, Equity, and Inclusion that impact their work.

Further DEI work occurred at the committee level. A DEI Committee was established in March, 2021, to make recommendations to the DVOMB to enhance service delivery related to cultural competency, implicit bias, trauma, and the broader social justice issues of racism and intersectionality. The committee charter also empowered it to identify training content areas for future DVOMB meetings and for Approved Providers. The Committee voted to rename itself in 2023 to the Diversity, Equity, Inclusion, and Belonging (DEIB) Committee to emphasize the goal of having DVOMB members and Approved Providers of minority race-ethnicity feel a sense of belonging within the DVOMB community. The DEIB Committee continued to meet monthly and address a range of issues including identifying training on DEIB issues that the DVOMB could facilitate, addressing language interpretation recommendations for standards revisions, and addressing inclusion of cultural competency and EDI awareness within the provider application process. The DEIB Committee received a presentation on understanding the assessment and treatment needs of gender diverse and transgender individuals, and participated in the evaluation of the effectiveness of that training.

Efforts to Recruit New Providers

The ODVSOM undertook a project in 2022 to develop a communications plan to attract new providers to the domestic violence and sex offender treatment fields. Together with marketing and research partner, Orange Circle Consulting (Orange Circle), the ODVSOM completed the formative research for the plan in 2022. The research involved surveying of individuals with potential to work as Approved Providers and individuals from stakeholder groups. Attention was given to the ethnic-racial composition of the respondents to ensure that any substantive differences between ethnic-racial groups could be identified. A summary of the main findings are in the 2023 DVOMB Annual Legislative Report.

The implications for communication and recruitment included a need to target specific audiences such as current therapists and students pursuing degrees in the behavioral health field. As well, development of internships and increasing mentorship opportunities provide both an opportunity to learn about the field and transition into provider roles. Communications and targeted messaging should showcase the intrinsic benefits of working in this field that align with prospective providers and highlight the positive outcomes of being a part of the work. Transparency in outreach concerning the nature of the work and perceived barriers was also seen as important, particularly to address concerns expressed by African American and Hispanic individuals. A concerted “positive public relations” outreach effect with internal audiences could also assist promote the proactive efforts of the ODVSOM to address application renewal concerns.

In 2023 the ODVSOM presented the formative research findings at the monthly meetings of the DVOMB and SOMB, including to stakeholder groups that were present. Both Boards and stakeholders showed a high degree of engagement with the intent of the communications and recruitment project. The feedback was positive and the process appeared to aid building a sense of community amongst stakeholders in the field. In 2023 the ODVSOM is continuing to work with Orange Circle to develop the specific outreach strategies and materials. The intention is to have the communication plan finalized by the end of 2023 with production of messaging materials and the outreach being undertaken in 2024.

Applications for Placement on the DVOMB Approved Provider List

During FY 2022-2023, the Application Review Committee of the DVOMB reviewed and approved a total of 74 applications for placement on the Approved Provider List, which equates to an approval rate of 95 percent. There were four pending applications and zero applications denied.

Table 8. DVOMB Count of Applications FY2022-23

Type	Approved	Pending	Denied	Total	Percentage
Trainee	26	1	0	27	96%
Associate Level[a]	19	1	0	20	95%
Full-Operating Level	2	1	0	3	67%
Domestic Violence Clinical Supervisor	4	0	0	4	100%
Move-Up	4	0	0	4	100%
Female Specific Offender Population	14	0	0	14	100%
LGBT+ Specific Offender Population	5	1	0	6	83%
Total	74	4	0	78	95%

[a] This was formally listed as Entry Level.

Current Availability of DVOMB Approved Providers

As of June 30, 2023, there were 153 active and 32 not currently practicing[24] treatment providers **approved by the DOMB in Colorado.** DVOMB Approved Providers may choose to pursue an addition of services with their status. For example, a treatment provider may also be approved to work with a Specific Offending Population: female offenders and LGBTQ+ offenders. Of those treatment providers, **121 were approved to work with female offenders** and **47 were approved to work with LGBTQ+ offenders**. **Table 9** provides the current statistics on the availability of service providers approved to operate in Colorado. **Figure 8** shows the number of Approved Providers by county.

It is important to note that the DVOMB recently approved changes to the qualifications in Section 9.0 regarding requirements to become a DVOMB Approved Provider. The Trainee status was replaced with an Associate Level Candidate status. Unlike the Trainee status, Associate Level Candidates will be listed on the DVOMB Approved Provider List after submitting Application 1 and being administratively approved by staff if they meet the minimum qualifications and have a Domestic Violence Clinical Supervisor. As a result of this change, the number of Approved Providers will likely see an increase when being reported in 2025.

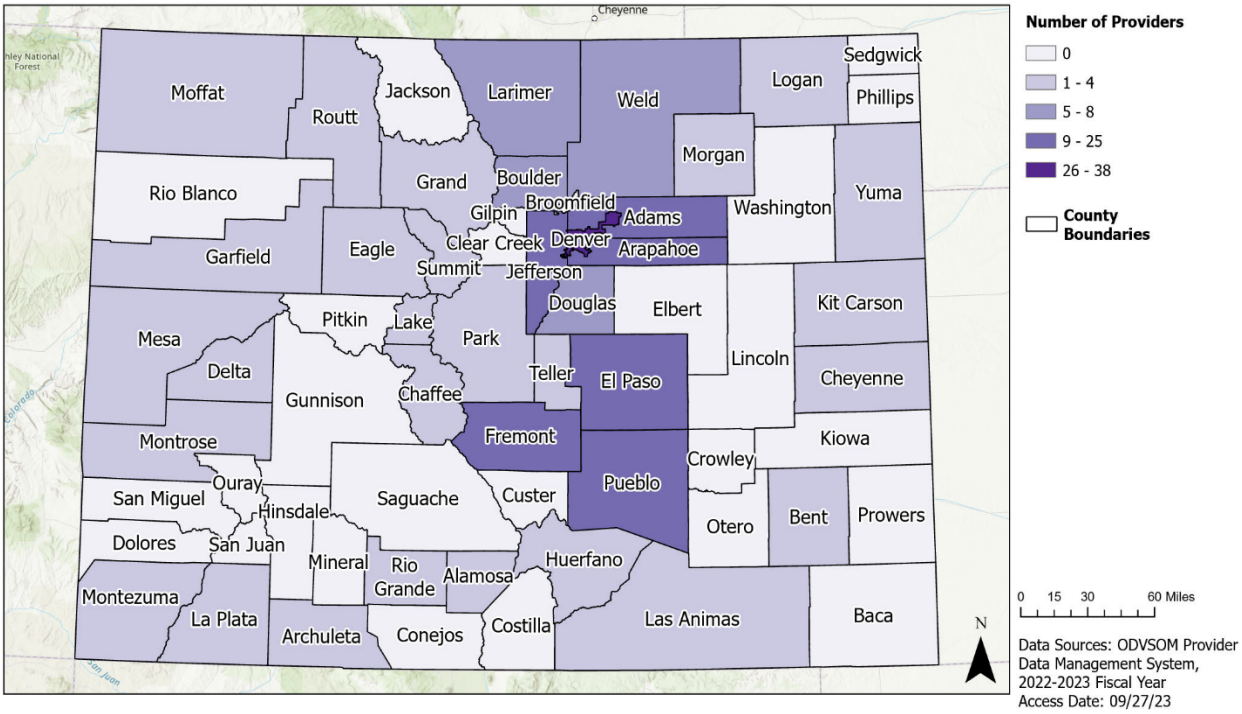
[24] If a Provider wishes to retain their listing status but is not providing any direct services for domestic violence, the Provider may request to be placed on Not Currently Practicing Status. During this time, a Provider will retain their status on the Provider List, but shall not provide any domestic violence offender services including treatment, evaluations, coverage, and peer consultation or clinical supervision.

Table 9. Number of Approved Providers in Colorado, FY2022-23

Level	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FY21-22	FY22-23
Provisional	3	1	4	3	2	2	1
Associate	24	26	26	40	35	36	39
Full Operating	106	103	81	88	94	90	82
Clinical Supervisor	41	53	45	35	37	31	29
Clinical Supervisor Apprentice[a]	-	-	-	-	-	-	2
Subtotal	174	183	156	166	168	159	153
Not Currently Practicing	19	21	23	21	23	16	32
Grand Total	193	204	179	187	191	175	185

[a] Clinical Supervisor Apprentice was a new provider category introduced in FY2022-23. It involves a period of training and oversight in clinical supervision prior to moving up to Clinical Supervisor.

Figure 8. Number of DVOMB Approved Providers by County. See Appendix A for chart table.



On average, Approved Providers operated in three different counties. In total, the DVOMB has Approved Providers located in all 22 judicial districts in the state.

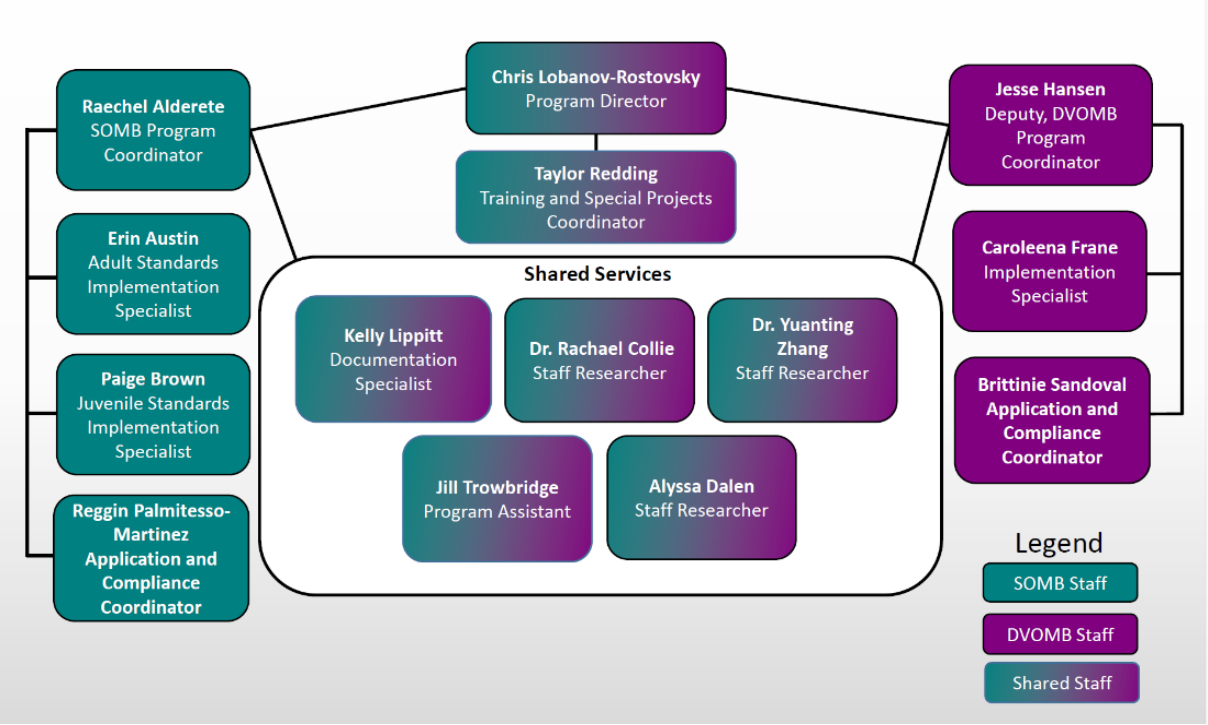
Update on the ODVSOM Shared Services Model

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 SOMB and 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 are expanding to include more efforts regarding program implementation and compliance monitoring of DVOMB Approved Providers.

To address these 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 led in 2022 to a revamp of staff responsibilities and produced a new staffing configuration referred to as the Shared Services Model, shown in **Figure 9**. Implementation of the model began in 2022 and has continued with expansion in 2023.

Figure 9. The ODVSOM Shared Services Model and Organizational Chart 2023.
See Appendix A for chart table.



In 2023, updated position descriptions were completed, two new positions were added arising from the reauthorization of the SOMB, Senate Bill 23-164, and areas of expertise systems improvements continue to develop.

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 previously 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 implementation specialists. The implementation specialists' roles focus 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.

Policy Updates

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 FY 2022-23, which were open to all stakeholders in order to work on statutorily mandated duties. These committees were:

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. A summary of the main work of each committee in FY2022-23 is provided in **Appendix B**.

Ongoing implementation

Ongoing implementation refers to the dissemination of information from the DVOMB to Approved 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 the 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 Approved 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 Approved Providers and stakeholders through the use of email lists for communication and a quarterly newsletter.

Training

In FY2022-23, the DVOMB provided 38 trainings to over 1400 attendees across Colorado, which included the ODVSOM annual conference attended in-person by over 500 stakeholders.[25] The trainings covered a range of topics related to the treatment and supervision of individuals convicted of domestic violence 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
- Community Roundtable Discussions
- Treatment Planning and Case Conceptualization
- A Stages of Change Model for Domestic Violence Assessment and Treatment
- Recognizing and Understanding the Assessment and Treatment Needs of Sexuality Gender Diverse (SGD) and Transgender Gender Diverse (TGD) Individuals
- How to Evaluate and Treat LGBTQ+ Domestic Violence Offenders
- Risk, Needs, and Responsivity Principles in Domestic Violence Supervision
- Domestic Violence State and Municipal Probation Training
- Parole Board Training on Domestic Violence Risk Factors
- Domestic Violence Dynamics for Case Workers with the Department of Human Services
- Maintaining Professional Boundaries
- Making Research Accessible and Applicable to Practitioners
- Phase 1: Preliminary Results of the DVRNA Validation Study
- Client Level Data Collection

Summary

The following highlights some of the many additional achievements of the DVOMB in FY2022-23:

- Managed six DVOMB committees
- Approved 74 applications for placement or continued placement on the DVOMB Approved Provider List during FY2022-23.
- As of July 2023, there were 153 active and 32 not currently practicing DVOMB Approved Providers in Colorado. Of those treatment providers, **111 are approved to work with female offenders** and **44 are approved to work with LGBTQ+ offenders.**

[25] In a few instances training was conducted in conferences in other States to share knowledge about the Colorado approach to evaluation and treatment of domestic violent offenders.

- Conducted 38 trainings to over 1,400 attendees from across Colorado. These trainings covered a range of topics related to the treatment and supervision of individuals convicted of domestic violence offenses. This included cohosting an four-day conference for DVOMB Approved Providers, supervising officers, victim advoacates, law enforcement, court personnel, and other stakeholders.

- Validated the Colorado Domestic Violence Risk and Needs Assessment (DVRNA) regarding its ability to determine the appropriate treatment level for domestic violence offenders at the time of assessment.

- 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.

- Shared findings with stakeholders about the characteristics that attract potential and current Approved Providers to the field identified in the formative research conducted with Orange Circle Consulting. This effort is to create a communication and recruitment strategy to increase the number of DVOMB Approved Providers across Colorado with specific focus on diversity, equity, and inclusion.

- Implemented new statutory requirement for DVOMB Approved Provider to submit client service-level data related to domestic violence offender services.

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. Data Tables

Table 6: Client Demographics

Gender (n = 413)	Number of Clients	Percent (of known)
Male	336	81%
Female	77	19%
Missing	24	NA

Age (n = 410)	Mean	Range
Age (At Time Of Offense)	34	17 to 64

Sexual Orientation (n = 410)	Number of Clients	Percent (of known)
Heterosexual	400	98%
Bisexual	6	1.5%
Gay/Lesbian	3	0.7%
Self-identify	1	0.2%
Missing	27	NA

Race/Ethnicity (n = 402)	Number of Clients	Percent (of known)
White	181	45%
Hispanic	154	38%
Black or African American	35	8.7%
Latino	12	3.0%
Native American or American Indian	11	2.7%
Asian or Pacific Islander	8	2.0%
Not listed here	1	0.2%
Missing	35	NA

Hispanic Origin (n = 271)	Number of Clients	Percent (of known)
Not Hispanic Origin	159 (59%)	59%
Mexican	84 (31%)	31%
Not Listed Here	25 (9.2%)	9.2%
Puerto Rican	*	*
Latino	*	*
Missing	166	NA

Primary Language (n = 273)	Number of Clients	Percent (of known)
English	246	90%
Spanish	26	9.5%
Not listed here	1	0.4%
Missing	164	NA

Highest Education (At Time of Offense) (n = 271)	Number of Clients	Percent (of known)
High school degree or equivalent (e.g., GED)	136	50%
Less than high school degree	51	19%
Bachelor degree	34	13%
Vocational schooling	19	7.0%
Associate degree	13	4.8%
Some college but no degree	13	4.8%
Graduate degree	5	1.8%
Missing	166	NA

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Figure 4: Number of Domestic Violence Treatment Clients by Referral Source (n = 412).*

Referral Source*	Number of Clients	Percent (%)
Probation	326	79.1%
Private Probation	40	9.7%
Community Corrections	14	3.4%
Parole	12	2.9%
Diversion	11	2.7%
Court	10	2.4%
Self-referred	6	1.5%
County DHS/DYS	4	1.0%
Other	4	1.0%

*Percentages do not add up to 100 % as more than one referral source may be selected for each treatment client

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Figure 5: Distribution of Treatment Levels Placed for Colorado DV Treatment Clients (n = 411).

Treatment Level	Number of Clients (n)	Percent (%)
Level A	18	4.4%
Level B	133	32.5%
Level C	258	63.1%

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Figure 6: Discharge Outcomes by Treatment Level Placed for Colorado DV Treatment Clients (n = 410)

Treatment Level A (n = 18)

Discharge Outcome	Number of Clients	Percent (%)
Completed Discharge	16	89%
Unsuccessful Discharge	2	11%
Administrative	0	0%

Treatment Level B (n = 134)

Discharge Outcome	Number of Clients	Percent (%)
Completed Discharge	108	80.6%
Unsuccessful Discharge	16	11.9%
Administrative	10	7.5%

Treatment Level C (n = 258)

Discharge Outcome	Number of Clients	Percent (%)
Completed Discharge	129	50.0%
Unsuccessful Discharge	106	41.1%
Administrative	23	8.9%

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Figure 7: Treatment Length for Colorado DV Treatment Clients by Treatment Level Placed (n = 408)

Treatment Level A (n = 18)

Discharge Type	Median Length of Treatment (Months)
Administrative	NA (no clients)
Completed	8.0
Unsuccessful	7.3

Treatment Level B (n = 131)

Discharge Type	Median Length of Treatment (Months)
Administrative	3.2
Completed	8.4
Unsuccessful	3.0

Treatment Level C (n = 258)

Discharge Type	Median Length of Treatment (Months)
Administrative	3.2
Completed	8.0
Unsuccessful	4.7

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Figure 8. Number of DVOMB Approved Providers by County

County Name	Number of Providers
Adams County	23
Alamosa County	2
Arapahoe County	25
Archuleta County	2
Baca County	0
Bent County	1
Boulder County	7
Broomfield County	0
Chaffee County	2
Cheyenne County	1
Clear Creek County	0
Conejos County	0
Costilla County	0
Crowley County	0
Custer County	0
Delta County	1
Denver County	38
Dolores County	0
Douglas County	6
Eagle County	1
El Paso County	21
Elbert County	0
Fremont County	16
Garfield County	4
Gilpin County	0
Grand County	1
Gunnison County	0
Hinsdale County	0
Huerfano County	2
Jackson County	0
Jefferson County	21
Kiowa County	0
Kit Carson County	1
La Plata County	4
Lake County	1
Larimer County	6
Las Animas County	1
Lincoln County	0
Logan County	1

County Name	Number of Providers
Mesa County	3
Mineral County	0
Moffat County	4
Montezuma County	1
Montrose County	2
Morgan County	1
Otero County	0
Ouray County	0
Park County	1
Phillips County	0
Pitkin County	0
Prowers County	0
Pueblo County	15
Rio Blanco County	0
Rio Grande County	1
Routt County	2
Saguache County	0
San Juan County	0
San Miguel County	0
Sedgwick County	0
Summit County	3
Teller County	1
Washington County	0
Weld County	8
Yuma County	1
Unknown County	6

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Figure 9. ODVSOM Shared Services Model and Organizational Chart 2023.

Position	Staff Member
ODVSOM Program Director	Chris Lobanov-Rostovsky
ODVSOM Training and Special Project Coordinator	Taylor Redding
SOMB Program Coordinator	Raechel Alderete
SOMB Adult Standards Implementation Specialist	Erin Austin
SOMB Juvenile Standards Implementation Specialist	Paige Brown
SOMB Application and Compliance Review Coordinator	Reggin Palmitesso-Martinez
ODVSOM Documentation Specialist	Kelly Lippitt
ODVSOM Staff Researcher	Dr. Rachael Collie
ODVSOM Staff Researcher	Dr. Yuanting Zhang
ODVSOM Staff Researcher (0.3)	Alyssa Dalen
ODVSOM Program Assistant	Jill Trowbridge
DVOMB Program Coordinator	Jesse Hansen
DVOMB Implementation Specialist	Caroleena Frane
DVOMB Application and Compliance Review Coordinator	Brittanie Sandoval

Note: ODVSOM (Office Domestic Violence and Sex Offender Management) are shared staff that support both the SOMB (Sex Offender Management Board) and DVOMB (Domestic Violence Management Board).

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Appendix B. DVOMB Committee Work

Executive Committee

Committee Chair: Stephanie Fritts
Committee Vice-Chair: Michelle Hunter
Members: Honorable Bradly A. Burbank, Karen Morgenthaler

Purpose: The Executive Committee represents the leadership of the Board and offers direction for agenda items based on Board discussion, statutory mandates, and directives. Membership of the Executive Committee includes the DVOMB Chair, Vice Chair, Applications Review Committee Chair, one At-Large Board Member who serves an appointment of two years, and DVOMB program staff as appropriate and necessary. The charge of the committee is to: (i) prioritize victim safety, support, and protection of confidentiality; (ii) provide policies and procedures for the effective governance of the Board; (iii) schedule and plan for DVOMB meetings at least once a quarter; and (iv) monitor Board engagement and attendance to ensure that appointed members are involved and meeting Bylaw requirements.

Major Accomplishments: The Executive Committee met monthly online for one hour throughout FY2022-23. The Executive Committee debriefed each monthly DVOMB meeting and planned for each upcoming meeting. Planning included identifying relevant updates from other DVOMB committees, organizing guest presentations on emerging and salient issues, as well as presentations to honor heritage and commemorative months and support diversity, equity and inclusion. The Executive Committee also attended to Board vacancies and provided oversight to attendance at DVOMB meetings.

Future Goals: The Executive Committee will continue to maintain the mission of the DVOMB and implement the outcomes from the 2021 Sunset Review.

Application Review Committee

Committee Chair: Karen Morgenthaler
Committee Vice-Chair: Michelle Hunter

Purpose: The Application Review Committee (ARC) serves as the delegated arm of the Board that is charged with decision making authority for applications, complaints, Standards Compliance Reviews, and other administrative action. The ARC consists of Board members who are appointed by the ARC Chair and confirmed through consensus by the Board. The charge of the ARC is to: (i) prioritize victim safety and support, as well as the protection of victim confidentiality; (ii) execute the delegated statutory mandates of the DVOMB regarding applications, complaints, Standards Compliance Reviews, and other administrative actions; (iii) ensure the applications and Approved Providers are adhering to the DVOMB Standards; (iv) identify and propose to the full Board changes, updates, and adjustments to the Standards; and (v) promote and recognize the best practices regarding the evaluation, assessment, and treatment of domestic violence offenders.

Major Accomplishments: The ARC met monthly throughout FY2022-23 for between three to five hours per meeting either online or in-person. The committee reviewed applications, complaints, compliance action plans, and variances in a timely manner. Major highlights include:

- The Committee reviewed a large number of applications for teletherapy approval alongside the regular volume of applications for trainee/candidacy, associate and full operating level, and clinical supervisor and specific offender population listings.

- The Committee managed, assessed, and resolved thirty-three complaints, many of which were already open at the beginning of FY2022-23 and pending review by the Department of Regulatory Authority (DORA) as required per Statute 16-11.8-103. The Committee received nine new complaints in FY2022-23 and had resolved 22 complaints by the end of FY2022-23. The majority of the complaints were dismissed by DORA or deemed unfounded by the ARC. A small number ended in voluntary or involuntary removal of the Provider from the DVOMB Approved Provider List. In the one appeal, the DVOMB upheld the finding of the ARC.

- The Committee managed four standards compliance reviews, one compliance action plan, and offered another compliance action plan that was declined by the Provider. The Committee voted to expand the membership of the ARC to allow non-Board members with expertise in specialized areas (e.g., LGBTQ+ issues) and representative of BIPOC communities to sit on the ARC.

Future Goals: Continue reviewing applications, complaints, compliance action plans, and variances in a timely and efficient manner. Develop and implement the compliance review quota of 10% compliance reviews every two-years required following the 2021 Sunset review and outlined in House Bill 22-1210. Continue to develop the capacity of the ARC to address issues of equity, diversity, and inclusion.

Standards Revisions Committee

Committee Chair: Erin Gazelka
Committee Vice-Chair: Jeanette Barich

Purpose: The Standards Revision Committee (SRC) convenes a membership of Approved Providers, Supervising Officers, and Treatment Victim Advocates (TVAs) to: (i) prioritize victim safety and offender treatment strategies that reduce recidivism by identifying and recommending possible revisions to clarify and update the Standards as delegated by the DVOMB; (ii) explore and incorporate any recently published research regarding evidence-based and/or research-informed practices; (iii) empower and solicit all affected stakeholders to participate and contribute to the revision process; (iv) improve the coordination and standardization of practices by domestic violence treatment providers working in conjunction with the members of the Multidisciplinary Treatment Teams (MTTs); (v) make recommendations to the DVOMB or other committees on matters related to the treatment and evaluation of domestic violence offenders.

Main Accomplishments: The SRC has met monthly online for two hours throughout FY2022-23. In addition, members of the committee have met as needed outside of formal meetings to further work on topics to bring back to subsequent meetings. The Committee primarily focused on systematic review and revision of Section 5.0 of the Standards and Guidelines: Offender Treatment, with an overall

objective of making the treatment standards more coherent, clear, and explicitly aligned with the Risk-Need-Responsivity (RNR) Principles and contemporary research. Major highlights include:

- Developing a Clinical Working Definition of Domestic Violence that reflects the ways coercive control and abusive behaviors present in intimate partner violence. The clinical working definition required drawing on evidence-based sources and Provider expertise. The clinical working definition was approved by the Board and ratified after review and address of public comment. It is now included in the *Standards and Guidelines*.

- Developing a Fidelity of Practice Principle that complements the other principles of effective intervention for domestic violence offenders (Section 5.01) that are annunciated. The fidelity principle refers to the degree the intervention adheres to a particular intervention theory or protocol and is typically achieved via having a clear treatment model, qualified and trained staff, and the provision of ongoing supervision and continuous improvement processes. The fidelity principle was approved by the Board and ratified after review and address of public comment. It is now included in the *Standards and Guidelines*.

- Revising the Offender Treatment Competencies to create a more coherent set aligned with risk-need evaluations, treatment planning, and treatment progress monitoring. The competency revision included moving from a lengthy list of competencies with some degree of duplication, to a more concise set of required and additional competencies organized around the categories of accountability, self-regulation and self-care, and survivor impact and community safety. The revised competencies align more clearly with risk-need assessment and the targets in treatment plans, thus allowing a clearer more coherent process for evaluating offender treatment progress. The revised competencies are in the process of final revision.

Future Goals: The SRC intends to finalize revision of the offender treatment competencies and continue to work through review and revision of the other parts of section 5.0. The SRC will continue to respond to emerging issues and requests from the field and the Board.

Diversity, Equity, Inclusion, and Belonging (DEIB) Committee

Committee Chair: Jennifer Parker
Committee Vice-Chair: Raechel Alderete

Purpose: The DEIB committee is open to Approved Providers, Supervising Officers, Treatment Victim Advocates, and other stakeholders with the aims of: (i) convening an ad hoc committee with a diverse membership of viewpoints and life experiences; (ii) exploring and making recommendations about DVOMB policies and procedures to support diversity, equity, and inclusion efforts; (iii) exploring and making recommendations about the 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; and (iv) identifying possible training content areas for future DVOMB meetings and for Approved Providers.

Major Accomplishments: The DEIB committee met monthly online for two hours throughout FY2022-23. The work of the committee addressed DEIB issues across workforce development, clinical practice, and multidisciplinary team practices. Highlights include:

- Adding the term “Belonging” to the committee title to emphasize the importance of being accepted and included by others to the mission of DEI work.

- Discussion of changes and strategies to increase BIPOC representation and participation as Approved Providers. This included reviewing the formative research conducted by Orange Circle Consulting to understand what motivates individuals, of different races-ethnicities, to consider and work in this field. It also included discussion of strategies to support non-BIPOC Approved Providers developing sufficient cultural competency-humility to work effectively with BIPOC clients, such as establishing consulting and support groups similar to those established in other professional fields.

- Participating in a presentation on DEIB issues for individuals from the LGBTQ+ community titled “understanding the assessment and treatment needs of sexuality gender diverse and transgender gender diverse individuals”.

- Identifying and supporting training on DEIB issues and working effectively with clients of minority/marginalized identities. The committee identified and recommended the ODVSOM offer Racial and Generational Trauma and Recovery Training (which was delivered September 2023). The committee also supported the emphasis on DEIB issues at the 2023 ODVSOM Annual Conference including having input into Cultural Panel Session and addressing cultural-racial safety issues at the conference.

- Identifying and discussing a need for greater attention in the standards to language needs and barriers such as use of interpreter services and/or use of interpretation device. The Committee has worked on developing a new standard to address this issue and is working through the standard and review process.

Future Goals: The DEIB Committee intends to continue to discuss, monitor, and address increasing BIPOC representation and participation among DVOMB Approved Providers and the Board. The Committee will continue to identify and recommend training, and respond to proposed revisions to the *Standards and Guidelines*, and emerging issues in the field.

Victim Advocacy Committee

Committee Chair: Jessica Fan
Committee Vice-Chair: Glory McDaniel

Purpose: The Victim Advocacy Committee (VAC) convenes a membership of Treatment Victim Advocates (TVAs), Victim Services Officers, Approved Providers, Supervising Officers, and other stakeholders to: (i) prioritize victim safety and support, as well as the protection of victim confidentiality; (ii) support victims of domestic violence having the right to make informed decisions about the degree of involvement with the TVAs; (iii) collaborate and provide support and resources to TVAs; and (iv) make recommendations related to DVOMB Standards and policies to the DVOMB or other committees on matters related to victim impact and safety, and best practices for TVAs.

Major Accomplishments: The VAC met on 10 months online for two hours during FY2022-23. The work of the committee addressed a range of victim advocacy issues including reviewing revisions to Section 7.0 of the Standards and Guidelines, which pertains to TVA qualifications, clarifying training and roles

between different professionals and agencies involved in victim advocacy, staying abreast of emerging training areas, and addressing resourcing needs. Highlights include:

- Discussing options, strategies, and preferences for TVAs to gain certification and qualification to meet TVA requirements. Also ongoing discussion about how best to ensure and manage victim confidentiality and privilege within the TVA role.

- Developing a definition and guidelines around dual roles potentially held by TVAs for inclusion in the Standards and Guidelines.

- Coordinating a presentation and panel discussion at a DVOMB meeting on the impact of domestic violence on children in recognition of domestic violence awareness month.

- Supporting a presentation on working with Latino victims of domestic violence.

- Providing a joint presentation with the SOMB Victim Advocacy Meeting at the ODVSOM annual conference to raise awareness across the Boards, Approved Providers, and other stakeholders about the role, challenges, and benefits of victim advocacy within offender evaluation and treatment.

- Holding a joint meeting with the SOMB Victim Advocacy Committee to identity and discuss areas of mutual concern and benefit.

Future Goals: The VAC intends to continue to identify, coordinate, and support training on relevant victim advocacy topics, including creating greater space for victim voices at the ODVSOM annual conference. The VAC also intends to continue to collaborate with the SOMB Victim Advocacy Committee on shared interests including resources for victims and potential evaluation of the outcomes of engaging with victim advocacy services.

Training Committee (Joint with SOMB)

Committee Chair: Jesse Hansen
Committee Vice-Chair: Nicole Feltz

Purpose: The Training committee convenes a membership of Approved Providers, Supervising Officers, TVAs, Victim Representatives, and other stakeholders to: (i) assist with identification of training topics and objectives, and provide support in the planning process of long-range and large-scale training events; (ii) define and assess the training needs for stakeholders affiliated in the fields of domestic violence and sex offender management; (iii) identify and develop trainers for sustainability purposes through collaboration with other agencies; (iv) collaborate and provide support to stakeholders based on availability and resources; (v) make recommendations to program staff on training needs and best practices; and (vi) support the development and planning of the annual conference.

Main Accomplishments: The Training Committee met on 10 months online for two hours during FY2022-23. The Committee debriefed the 2022 ODVSOM Annual Conference and prepared for the 2023 conference. The Committee's work included coordinating and preparing for the ODVSOM Advanced Series trainings and the DVOMB Lunch and Learn trainings and additional trainings. As well as coordinating a significant number of domestic violence specific trainings, the Committee increased the number of trainings that were relevant to both DVOMB and SOMB Approved Providers, creating

efficiencies, greater options for providers, and supporting cross-interest and learning between the fields.

Future Goals: The Training Committee is continuing to plan for training events and finding opportunities for conjoint DVOMB and SOMB training events. The Committee is also working on creating opportunity for inclusion of greater victim voices at the ODVSOM conference and continuing to support EDI and cultural awareness within training.

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