DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD

ANNUAL LEGISLATIVE REPORT

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

A Report of Findings Pursuant to 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., this report fulfills the requirements that on or before January 31, 2023, and on or before each January 31 thereafter, the Domestic Violence Offender Management Board (DVOMB) shall prepare and present a written report to the House of Representatives Judiciary Committee and the Senate Judiciary Committee, or their successor committees.

This annual report presents findings from an examination by the DVOMB of best practices for the treatment and management of individuals who have committed domestic violence offenses.

This report is a product of the 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 the Colorado 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

Core Treatment Competencies

In 2024, the DVOMB revised the treatment competencies outlined in its *Standards and Guidelines for the Evaluation, Assessment, Treatment, and Monitoring of Domestic Violence Offenders* (hereafter the *Standards and Guidelines*). These updates integrate the latest empirical research on dynamic risk factors (criminogenic needs) and treatment effectiveness, aiming to enhance alignment between evaluation, treatment planning, and progress monitoring. The revisions reflect insights from research presented in the DVOMB 2023 annual legislative report and 2024 annual legislative report and were informed by subject matter experts, including Approved Providers, victim advocates, and supervising officers.

The revised approach centers on evidence-based principles derived from the Risk-Need-Responsivity (RNR) model, which emphasizes tailoring treatment to an offender's risk level, targeting criminogenic needs, and applying responsive treatment methods. The framework consists of 11 core treatment competencies mandatory for all clients and 10 potential competencies that can be included as focus areas in treatment based on clinical need. This individualized strategy ensures appropriate treatment intensity, minimizing both overtreatment and undertreatment.

The core competencies fall into three categories:

1. **Domestic Violence and General Criminality**
   These focus on accepting responsibility and accountability, identifying patterns of abusive behavior, challenging cognitive distortions, and managing dynamic risk factors. The research underscores the importance of addressing coercive control, antisocial attitudes, and other criminogenic needs to reduce recidivism effectively.

2. **Regulation and Self-Care**
   These aim to develop emotional regulation, stress management, and life skills that can exacerbate domestic violence and general criminality risk factors. Also addressed are unresolved trauma and fostering prosocial activities. Strengths-based and trauma-informed approaches support offenders in building protective factors and adopting healthier coping mechanisms.

3. **Survivor Impact and Community Safety**
   These enhance understanding of the effects of abuse on victims, promote empathy as appropriate, and emphasize safety planning and compliance with supervision requirements. Intergenerational patterns of violence and fostering accountability through victim-centered and restorative practices are also addressed.

The competency-based framework supports the use of diverse therapeutic approaches aligned with cognitive-behavioral methods, trauma-informed care, and strengths-based models. By targeting criminogenic needs and leveraging protective factors, the updated competencies aim to reduce domestic violence recidivism and support offenders in achieving sustainable, non-violent lifestyles.

Use of Teletherapy for Domestic Violence Offender Treatment

The DVOMB permitted teletherapy as a treatment modality on March 13, 2020, in response to the COVID-19 pandemic. Previously prohibited, teletherapy became a vital tool to ensure continued treatment, reduce risks to victims, and support community safety. Although in-person therapy remains the preferred approach, teletherapy is now an ongoing option under specific conditions outlined in *Appendix I of the Standards and Guidelines*.

The use of teletherapy has grown significantly since the COVID-19 pandemic, but its effectiveness in offense-specific treatments, like those for domestic violence offenders, remains understudied. While meta-analyses show teletherapy is as effective as in-person therapy for various mental health issues, offense-related treatments differ substantially due to their mandatory nature, group settings, extended duration, focus on victim safety, and the complex needs of justice-involved clients, which may pose challenges in virtual settings.

In 2024, the DVOMB undertook a project to analyze the use of teletherapy for domestic violence offender treatment. The analysis involved 1,448 client records entered into the DVOMB Provider Data Management System (PDMS) between January 1, 2023, and January 23, 2024.

Key findings:

1. **Trends in Use**

   - Teletherapy is employed widely, with 45% of clients receiving domestic violence treatment exclusively online.

   - Low-risk (Level A) and moderate-risk (Level B) clients are more likely to receive teletherapy, while high-risk (Level C) clients more often undergo in-person treatment.

   - However, teletherapy was the sole treatment for 39% of high-risk clients, raising concerns about its suitability for this group.

2. **Completion Rates**

    - Teletherapy showed marginally higher treatment completion rates than in-person therapy, particularly for low and moderate-risk clients.

    - Mixed modality approaches and those that combined group and individual therapy achieved the highest completion rates for high-risk clients.

3. **Duration of Treatment**

    - Treatment lengths were similar across modalities for moderate and high-risk clients, suggesting adherence to guideline requirements.

    - Low-risk clients spent longer in teletherapy than in-person treatment.

4. **Appropriateness**

    - Factors indicative of greater criminality and antisociality (such as pro-violence attitudes, substance abuse, violation of conditions, and prior domestic violence convictions), mental health needs, and less than a high school diploma were linked to unsuccessful discharge from teletherapy.

5. **Research Insights and Limitations**

    - Teletherapy's effectiveness for domestic violence treatment, particularly in reducing recidivism, remains under-researched.

    - The absence of data on recidivism outcomes limits the evaluation of long-term safety and treatment efficacy. Of concern is that teletherapy's observed high completion rates may reflect greater ease of completing treatment via teletherapy rather than sustained behavioral change.

    - The DVOMB Application Review Committee (ARC) has established a Teletherapy Workgroup to revise the *Standards and Guidelines* concerning the use of teletherapy. While teletherapy will remain a treatment option, the Board will continue prioritizing in-person treatment for high-risk clients and enhance the *Standards and Guidelines* to align teletherapy use with client risk levels and criminogenic needs. Future research will study the impact of teletherapy on recidivism and victim safety, analyzing fidelity to treatment standards and outcomes across different modalities.

DVOMB Data Analysis

In June 2022, the Colorado Legislature passed House Bill 22-1210, mandating the DVOMB to develop and implement a data collection plan for Approved Providers by January 1, 2023. The DVOMB responded by developing the PDMS and partnering with ReliaTrax, enabling providers to submit client-level data efficiently while avoiding duplicate entries. Training sessions on the mandate and data collection processes were conducted between October and December 2022. Full data collection began in January 2023, with technical assistance provided throughout implementation. The current reporting period represents the first full 12-month year of data collection and is referred to as Year 1.

Key Findings from Year 1 (July 1, 2023–June 30, 2024):

- **Volume and Coverage**: Providers submitted 1,994 client records, a significant increase from the amount submitted during the initial six-month implementation phase (Year 0; January 1, 2023–June 30, 2023). The data encompassed 21 of Colorado's 23 judicial districts.

- **Client Characteristics**: Clients were predominantly male (81%), with an average age of 34. Approximately 47% were from BIPOC communities, with English as the primary language for 92% and Spanish for 8%. Over 75% consented to share personal data to enable future recidivism research. Almost 25% had prior domestic violence offender treatment. Most (86%) were referred by probation.

- **Risk and Treatment Levels**: Most clients (72%) were placed in high-intensity Level C treatment. Most clients (81%) maintained the same risk level throughout therapy. Adjunct treatment for Level B and C clients was mostly mental health treatment (43%) or substance abuse treatment (37%).

- **Responsivity Factors**: Client factors (25%) and finances (20%) were the most common responsivity barriers affecting client response to interventions. Vouchers (22%) and adjusting treatment modalities (10%) were the most common strategies reported to improve treatment responsivity.

- **Treatment Discharge Outcomes**: 57% of clients successfully completed treatment, while 37% had unsuccessful discharges, largely due to non-compliance or excessive absences. Discharge outcomes correlated with risk levels, with higher-risk clients showing lower completion rates.

- **Treatment Duration**: Treatment duration ranged from 0 to 36 months, with a median of 9 months for clients who successfully completed treatment and 3 months for clients who were unsuccessfully discharged.

- **Treatment Absences**: Greater treatment absences were associated with higher risk levels, while hybrid in-person and teletherapy modalities were associated with fewer absences. Excessive absences remained a notable challenge, with 60% of clients missing four or more sessions.

- **Treatment Modalities**: 45% of clients received in-person sessions only, 45% received teletherapy only, and 9% received hybrid in-person and teletherapy.

The Year 1 data demonstrates improved representativeness and reporting fidelity compared to the initial six-month implementation phase, providing more comprehensive insights into the population served. However, some judicial districts and providers remain underrepresented, and missing data continues to pose challenges. The DVOMB plans to refine the data collection process, provide additional training, and leverage qualitative data where appropriate to enhance future revisions to the *Standards and Guidelines*.

The implementation of HB 22-1210 has established a robust framework for collecting and analyzing data on domestic violence offender treatment in Colorado. The findings underscore adherence to evidence-based practices and highlight areas for policy development and program improvement. With continued refinement, the PDMS can serve as a model for advancing domestic violence offender management practices statewide and potentially nationally.

Section 2: Relevant Policy Issues and Recommendations

Section 2 of the DVOMB annual report outlines significant policy issues and recommendations identified by the DVOMB to enhance domestic violence prevention and intervention in Colorado, as mandated by HB 22-1210. These recommendations address systemic challenges and legislative gaps to improve offender accountability, victim safety, and the efficacy of domestic violence treatment services statewide.

Key Policy Issues and Recommendations:

1. ***United States v. Rahimi* and Firearm Restrictions**
   The Supreme Court decision in *United States v. Rahimi* affirmed the constitutionality of firearm prohibitions for individuals posing credible threats to intimate partners. The DVOMB emphasizes the importance of implementing and enforcing red flag laws in Colorado to mitigate risks posed by domestic violence offenders.

2. **Kayden's Law and Reunification Challenges**
   House Bill 23-1178 (Kayden's Law) introduced protective measures for children in family legal proceedings involving abuse allegations. However, language requiring DVOMB Approved Providers to "verify the accused party's behavior" in civil reunification cases presents impractical professional and liability risks.
   Recommendation: Amend 14-10-127.5, C.R.S., to remove or revise this requirement, as it falls outside the DVOMB's purview and established standards.

3. **Specialized Domestic Violence Parole Caseloads**
   A pilot project by the Division of Parole demonstrated the potential benefits of specialized caseloads for domestic violence offenders. Specialized caseloads involve targeted supervision strategies that may reduce recidivism, enhance accountability, and increase victim safety.
   Recommendation: Support the creation and expansion of domestic violence–specific parole caseloads and treatment requirements for parolees.

4. **Safety Protections for DVOMB Approved Providers**
   DVOMB Approved Providers face occasional but significant threats, including intimidation, harassment, and stalking, from domestic violence offenders. These risks undermine recruitment and retention efforts for highly skilled professionals critical to community safety.
   Recommendation: Extend the special class of protected victims to that of DVOMB Approved Providers and Treatment Victim Advocates similar to that of other protections identified in § 18-3-203, C.R.S., for peace officers, firefighters, emergency medical providers, etc. Individuals who commit or threaten acts of violence, harassment, or stalking against DVOMB Approved Providers or Treatment Victim Advocates should warrant higher criminal or civil penalties. This does not preclude a defendant from filing formal complaints against an Approved Provider with the DVOMB or any other regulatory organization.

The DVOMB remains committed to advancing policies and practices that reduce intimate partner violence, improve systemic responses, and support the professionals working to address these complex issues. These recommendations aim to create safer communities and enhance the effectiveness of domestic violence interventions across Colorado.

Section 3: Milestones and Achievements

During FY 2024, the DVOMB achieved significant milestones, advancing domestic violence offender treatment and supervision across Colorado. The Board's efforts aligned with legislative mandates, particularly those outlined in HB 22-1210, and focused on enhancing compliance, data collection, and best practice initiatives.

Key achievements include:

- **Reauthorization Requirements:** The DVOMB continues to meet the requirements of HB 22-1210. The data collection plan became operational on January 1, 2023. As of the date of publication, 16 SCRs have been initiated, more than the 10% of Approved Providers requirement. The 2025 DVOMB Annual Legislative Report provides an update on these efforts and represents the third year such a report has been prepared for the House and Senate Judiciary Committees.

- **Cultural Responsivity Efforts:** The DVOMB continues to prioritize culturally responsive care efforts through various initiatives to foster a respectful and inclusive environment. These include recruiting diverse Board members, providing cultural competency training for Approved Providers, and developing policies to address inappropriate remarks at training events hosted by the DVOMB.

- **Efforts to Recruit New Providers:** The DVOMB has expanded outreach and recruitment efforts to attract new providers, partnering with Orange Circle Consulting (Orange Circle) to design targeted messaging and resources, including videos highlighting the positive impact of becoming an Approved Provider.

- **Community and Stakeholder Outreach:** Engagement is a central focus, with traveling board meetings and roundtable discussions held across the state to improve collaboration and exchange feedback. Furthermore, the DVOMB successfully assisted in the formation of the Montrose County Domestic Violence Taskforce, which now meets regularly to address local challenges and opportunities in preventing domestic violence.

- **DVOMB Provider Survey and Field Assessment:** The DVOMB conducted the first Approved Provider Survey to assess treatment service fees and monitor the health of the domestic violence offender treatment field. The survey identified several challenges related to collecting payment for services and arising from referrals being more complex and higher risk post-pandemic. The survey explored the benefits of teletherapy modality for physical and emotional safety from the providers' perspective.

- **DVRNA-R Pilot:** The DVOMB initiated a project to revise the DVRNA based on recent validation study findings and emerging practices in risk management.

- **Provider Management:** The ARC managed 191 provider applications, maintaining a network of 171 active Approved Providers, 132 of whom were approved to work with female clients and 59 with LGBTQIA+ clients.

- **Policy Updates:** The DVOMB significantly revised sections of the *Standards and Guidelines*, incorporating statutory updates, empirical best practices, and culturally responsive approaches.

- **Training and Implementation Support:** The DVOMB delivered 40 training events attended by over 1,700 participants statewide, including a four-day annual conference for diverse stakeholders. The DVOMB continued monthly technical assistance sessions to support providers in understanding and implementing the *Standards and Guidelines*.

Operating through six active committees, the DVOMB successfully managed compliance reviews, supported statutory reauthorization requirements, and implemented a robust PDMS. By prioritizing stakeholder engagement, advancing EDI initiatives, and integrating empirically informed practices, the DVOMB continues to strengthen its mission to reduce domestic violence recidivism and promote effective, culturally sensitive treatment and supervision statewide.

Introduction

Report Purpose

Pursuant to § 16-11.8-103 (5.5), C.R.S., this annual report presents findings from an examination by the Domestic Violence Offender Management Board (DVOMB) of best practices for the treatment and evaluation of domestic violence offenders. This report fulfills the statutory mandate by including:

(a) The number of people who received domestic violence offender treatment in the preceding year, the number of those who successfully completed the treatment, the number of those who did not complete the treatment, and the number of those who reoffended and were removed from treatment;

(b) The number of treatment providers who provided domestic violence offender treatment in the preceding year;

(c) The number of treatment providers who applied to be placed on the list of approved treatment providers pursuant to subsection (4)(a)(III)(C) and the number of treatment providers placed on the list;

(d) The best practices for the treatment and management of domestic violence; and

(e) Any other relevant information, including any Board recommendations for legislation to carry out the purpose and duties of the Board to protect the community.

Background of the DVOMB

The General Assembly created the DVOMB in July 2000, pursuant to § 16-11.8-103, C.R.S. The DVOMB staff are located within the Office of Domestic Violence and Sex Offender Management in the Division of Criminal Justice, Colorado Department of Public Safety. The legislative declaration in the Board's enabling statute states that the consistent and comprehensive evaluation, assessment, treatment, and continued monitoring of domestic violence offenders at each stage of the criminal justice system is necessary to lessen the likelihood of re-offense, to work toward the elimination of recidivism and to enhance the protection of current and potential victims (§ 16-11.8-101 C.R.S.).

The Board was charged with the promulgation of Standards for the Evaluation, Assessment, Treatment, and Monitoring of Domestic Violence Offenders defined in § 16-11.8-102, C.R.S. (referred to as the *Standards and Guidelines*) and the establishment of an application and review process for Approved Providers who provide services to domestic violence offenders in the state of Colorado. The evaluation, assessment, treatment, and behavioral monitoring of domestic violence offenders shall only be provided by those individuals whose names appear on the DVOMB Approved Provider List (pursuant to § 16-11.8-104(1)).

The Board is committed to carrying out its legislative mandate to enhance public safety and the protection of victims and potential victims through the development and maintenance of comprehensive, consistent, and effective standards for the evaluation, assessment, treatment, and behavioral monitoring of adult domestic violence offenders. The Board continues to explore the developing literature and research on the most effective methods for intervening with domestic violence offenders and identify best practices in the field. According to the statute, treatment is defined as "therapy, monitoring, and supervision of any domestic violence offender which conforms to the standards created by the board" (§ 16-11.8-102 C.R.S.). The *Standards and Guidelines* thus govern the practice of mental health professionals who meet the qualification requirements and are approved by the Board.

Purview

The DVOMB has purview over guilty pleas, Pleas of nolo contendere, convictions after criminal trials, deferred sentences, and stipulation/finding of a domestic violence factual basis (§ 16-11.8-103(4)(a)(II) C.R.S.). The *Standards and Guidelines* apply for adult domestic violence offenders whose *criminal* charges include an underlying factual basis of domestic violence (§ 18-6-800.3, C.R.S.) and are required to undergo an evaluation and treatment by a DVOMB Approved Provider as:

- Ordered by the court to be placed on state probation, municipal, or private probation.
- Ordered by the Parole Board per the parole agreement.
- Ordered as part of the community corrections sentence (i.e., direct sentence, DOC inmates occupying state funded community correction beds).
- Ordered to complete as part of a pre-sentence offender evaluation.
- In cases where the domestic violence offender enhancer/tag has been removed from the court filing, domestic violence offender treatment may still be ordered if the court makes a finding that undergoing treatment is reasonably related to the defendant's rehabilitation, community safety, or the goals of probation.

In addition, individuals who are not under the purview of the Board or the criminal justice system may, at times, require evaluation, assessment, treatment, and supervision for domestic violence. DVOMB Approved Providers can use the *Standards and Guidelines* as best practice recommendations at their discretion in these cases. Appropriate instances include adults placed on diversion without a deferred sentence, adults requesting a pre-plea evaluation, adults requesting a domestic violence evaluation as part of a domestic relations or civil protection order case (§ 14-10-124, C.R.S.), individuals receiving services for domestic abuse behavior from a County Department of Human Services/Social Services (DHS/DSS) without a legal requirement, and persons voluntarily entering treatment due to self-disclosed behaviors related to domestic violence.

It is not the intention of the legislation or the DVOMB for the *Standards and Guidelines* that these be applied to the treatment of juveniles who have engaged in teen dating violence or relationship abuse. While there are many similarities in the behavior and treatment of juveniles and adults, significant differences exist in their developmental stages, the nature of their offending behavior, and the context in which they function. Consequently, these factors must be addressed differently in juveniles' diagnosis and treatment.

Section 1: Research and Evidence-based Practices

The DVOMB is mandated by §16-11.8-103(4)(a)(I), C.R.S., to establish and implement a standardized procedure for the treatment and evaluation of domestic violence offenders. Additionally, as per sections 5.5(a) and (d), the DVOMB must report on the number of individuals who have undergone domestic violence offender treatment in the preceding year, the outcomes of that treatment, and the best practices for treating and managing domestic violence. To fulfill these requirements and ensure that the *Standards and Guidelines* reflect best practices, the DVOMB collects client-level treatment data, conducts relevant data analysis projects, and undertakes regular research literature reviews.

The following section highlights some of the significant work undertaken by the DVOMB during FY 2024 to fulfill these statutory mandates. First, it summarizes the empirically informed revisions to the treatment competencies in the *Standards and Guidelines*. Second, it highlights findings from a project that reviewed best practices for using teletherapy for domestic violence offender treatment. Lastly, it presents critical client treatment and discharge outcomes collected through the DVOMB Provider Data Management System (PDMS) for FY 2024 (Year 1).

Empirically Informed Revisions to the Treatment Competencies

In 2024, the DVOMB revised the treatment competencies that clients should gain from completing domestic violence offender treatment. The purpose was to update the competencies in the *Standards and Guidelines* to (i) reflect advances in empirical research concerning dynamic risk factors (also referred to as criminogenic needs) and treatment effectiveness and (ii) create greater coherence between evaluation, treatment planning, and progress monitoring. The revisions were built upon prior research reviews on the dynamic risk factors for domestic violence recidivism and treatment effectiveness highlighted in the DVOMB 2023 Annual Legislative Report and 2024 Annual Legislative Report, as well as from subject matter expertise from providers, victim advocates, and supervising officers.

Section 5.03 (II) of the *Standards and Guidelines* outlines the revised core treatment competencies that should be addressed and developed as part of domestic violence offender treatment. Competencies are a set of defined knowledge, attitudes, and skills, which in domestic violence offender treatment effectively address clients' risk-related problems and develop comprehensive protective factors. Achieving these competencies is integral to establishing healthy, non-abusive relationships and desisting from offending. The *Standards and Guidelines* specify 11 core competencies required for all clients and 10 additional optional competencies that should be added to treatment plans as clinically indicated. This approach ensures treatment is individualized to clients' specific risk levels and treatment needs. It is evidence-based, aligning the intensity, duration, and focus of treatment to provide higher-risk clients with more overall treatment and lower-risk clients with less. This approach minimizes the chances of both overtreatment and undertreatment commensurate with risk and need level.

Competency achievement is consistent with the Risk-Need-Responsivity (RNR) model and principles of effective offender rehabilitation (Bonta & Andrews, 2024; Simourd & Olver, 2019; Stewart et al., 2014). Research has shown that programs that follow these principles are more effective at reducing domestic violence recidivism (Travers et al., 2021). The three core principles of the RNR model involve (i) matching treatment dosage to risk level, with higher-risk individuals receiving more intensive treatment than lower-risk individuals (i.e., the risk principle); (ii) targeting treatment at changeable, dynamic risk factors known as criminogenic needs (i.e., the need principle); and (iii) using treatment methods that promote engagement and learning for justice-involved populations given their characteristics and learning needs (i.e., the responsivity principle).

Having treatment goals articulated as required and additional competencies provides a means to scale treatment intensity, target core criminogenic needs to reduce recidivism, develop skills to maximize participation and benefits from treatment, and individualize treatment (Morrison et al., 2018; Simourd & Olver, 2019; Smith et al., 2009). It also allows providers to use various therapeutic models and diverse treatment approaches to achieve these competencies while emphasizing strengths-based and trauma-sensitive interventions.

The following section outlines the revised core treatment competencies in the *Standards and Guidelines* and highlights supporting empirical research for these competencies. The additional optional competencies are listed in the *Standards and Guidelines Section 5.05 Implementation of Individual Treatment Plan*. The competencies are grouped under three labels to indicate the type of criminogenic needs and protective factors they target.

Core Treatment Competencies

Domestic Violence and General Criminality Treatment Competencies

Four core competencies address the central features found in domestic violence offenders consistent with an RNR treatment approach, namely:

> **Competency 1**: Define all types of domestic violence and abusive behavior and demonstrate acceptance of accountability and responsibility for offending and abusive behaviors.
>
> **Competency 2**: Identify the history of current and former patterns of domestic violence behaviors and thoughts regarding onset, frequency, and persistence.
>
> **Competency 3**: Identify and challenge cognitive distortions and belief systems that play a negative or unhealthy role in the client's thoughts, emotions, and behaviors.
>
> **Competency 4**: Recognize and manage dynamic risk factors and develop adaptive skills to mitigate those risk factors.

Research has shown that taking personal responsibility and having an internal locus of control protect against physical domestic violence (Friedman et al., 2022; Spencer & Stith, 2020; Spencer et al., 2022). Relatedly, problem recognition is integral to behavioral change and the therapeutic process (Day et al., 2006), while denial of responsibility is linked to treatment non-completion (Olver et al., 2011). In one recent study, for example, Friedman et al. (2022) found that men who completed a community-based domestic violence offender treatment program showed greater personal responsibility for their domestic abuse and reported greater use of healthy communication of needs to others, particularly

intimate partners. In that study, program completion was associated with fewer rearrests for domestic violence than program non-completion over an eight-year follow-up period (19% vs. 53%). Other studies have also reported that participants describe benefiting from discussing various types of intimate partner abuse, such as coercive control, during domestic violence offender treatment as it helps them recognize their own abusive behavior (e.g., Holtrop et al., 2017; Morrison et al., 2018).

The *Standards and Guidelines* emphasize that understanding coercive control is an essential aspect of taking responsibility for domestic violence and abusive behavior. Coercive control includes psychological elements (e.g., jealousy, psychological abuse, stalking, and suicide threats) as well as controlling attitudes (i.e., controlling behavior, attitudes supportive of domestic violence, and denial of domestic violence) (Hilton et al., 2023). Research shows that coercive control is a strong predictor of physical domestic violence and is linked with the severity of violence (Hilton et al., 2023; Spencer & Stith, 2020; Spencer et al., 2022). It has also been confirmed that coercive control is present in female-perpetrated domestic violence offenses as well as in same-sex domestic violence (Callan et al., 2021; Dixon et al., 2022; Rolle et al., 2018; Spencer et al., 2022).

Discussion on domestic violence often emphasizes the cyclical or repetitive nature of coercive control and abuse, although no single pattern describes the variability evident within intimate partner violence (Burge et al., 2016). Having clients understand their history of domestic violence can aid in recognizing this pattern and the associated criminogenic needs that create risk for future domestic violence and should be the focus of treatment. Research also indicates that individuals who commit intimate partner violence often perceive it as an adverse event (Giordano et al., 2015); therefore, reflection on their history of violence can assist in the process of redefining domestic violence and motivating desistance (Giordano, 2022; Giordano et al., 2015; Morrison et al., 2023). This cognitive transformation also addresses antisocial attitudes and problematic beliefs that promote and maintain domestic violence (Hilton & Radatz, 2021).

Antisocial attitudes and beliefs that promote, normalize, or minimize domestic violence maintain risk for domestic violence recidivism and are critical criminogenic needs (Chandra et al., 2024; Hilton & Radatz, 2018, 2021; O'Leary et al., 2007; Pornari et al., 2018; Spencer et al., 2022; Stewart & Powers, 2014). In contrast, healthy relationship beliefs are protective factors against domestic violence (Spencer & Stith, 2020). It has also been confirmed that an association between attitudes and domestic violence is present for female perpetrators (Copp et al., 2019). Several studies have found that men report that domestic violence offender programs lead them to become more aware of their own cognitive distortions and core beliefs related to domestic violence (McGinn et al., 2020; Morrison et al., 2018; Parra-Cardona et al., 2013). In keeping, it has been shown that treatment programs focusing on criminogenic attitudes, beliefs, and values among domestic violence offenders can reduce domestic violence recidivism (e.g., Cotti et al., 2019; Murphy et al., 2020; Zarling et al., 2020; Zarling & Russell, 2022).

Research indicates several broad criminogenic needs predict domestic violence recidivism in addition to attitudes and beliefs. These include coercive control, antisocial personality traits, substance use problems, pathological anger and emotion regulation difficulties, and employment problems (Farzan-Kashani & Murphy, 2017; Gerstenberger et al., 2019; Grace et al., 2023; Hilton & Radatz, 2021; Hilton et al., 2023). These broad risk domains may also contain more specific risk factors for domestic violence (Fortune & Heffernan, 2021), such as emotional-psychological-verbal abuse, controlling behaviors, jealousy, relationship conflict, approval of domestic violence, and externalization of blame. A notable lethality risk factor is direct access to firearms (Spencer & Stith, 2020). Studies evaluating

the effectiveness of domestic violence offender treatment programs have shown that treatments that target these criminogenic needs using cognitive-behavioral approaches show success at reducing domestic violence recidivism (Bloomfield & Dixon, 2015; Blatch et al., 2016; Cotti et al., 2020; Gannon et al., 2019; Lawrence et al., 2021; Stewart et al., 2014; Tollefson & Phillips, 2015; Travers et al., 2021; Zarling, et al., 2020; Zarling & Russell, 2022).

Self-Regulation and Self-Care

Three core competencies were developed that address central features of self-regulation and self-care consistent with a strengths-based and trauma-informed approach, namely:

> **Competency 5**: Demonstrate and implement self-regulation skills, including, but not limited to, emotional regulation, stress management, communication skills, anger management, conflict resolution, problem-solving, delayed gratification, and parental and financial responsibility.
>
> **Competency 6**: Demonstrate the ability to discuss past experiences and how any unresolved trauma may impact offending behavior as a way to adopt effective coping strategies.
>
> **Competency 7**: Develop and maintain prosocial activities and networks to include but not limited to completing education, maintaining employment, obtaining stable housing, life skills, recreational and social activities, etc.

Risk factors interconnect in complex ways to influence the recurrence of domestic violence (Douglas & Skeem, 2005). Some factors have a direct impact on perpetuating domestic violence, such as core beliefs that view violence as acceptable in relationships. Others operate indirectly, like poor anger management, by intensifying a sense of entitlement to use violence in certain situations (Czarnietzki et al., 2024; Foster et al., 2024). The self-regulation and self-care competencies address factors that are empirically related to increased risk of domestic violence, especially when the central features of domestic violence and general criminality are present. Poor self-regulation, past trauma, and limited prosocial activities do not, by themselves, cause domestic violence. However, when present with core domestic violence and criminality risk factors, they are important treatment areas.

Self-regulation skills refer to the ability to manage and control emotions, behaviors, and thoughts in a way that helps achieve goals and respond to situations appropriately (Inzlicht et al., 2021). Self-regulation is essential for emotional wellbeing, maintaining healthy relationships, and successful employment, while self-regulation failure is linked to behavioral disorders and domestic violence risk factors (Le Berre, 2019; Maloney et al., 2023; Roos et al., 2022; Stellern et al., 2023; Strauman, 2017). Consistent with the emphasis on self-regulation skills, research shows protective factors against domestic violence include relationship satisfaction, communication skills, coping skills, conflict resolution skills, higher income, empathy, higher self-esteem, higher education, and older age (Spencer et al., 2022). As well, domestic violence offender treatment programs have been shown to improve communication and listening skills (Morrison et al., 2018; Smith, 2011), perspective-taking and empathy development, confidence in one's ability to enact skills and achieve goals, and assertiveness (Scott & Wolfe, 2000; Scott & Wolfe, 2003; Smith, 2011). Further, men in treatment programs report acquiring tools to manage intense emotions and conflict in healthier ways (Holtrop et al., 2017; Morrison et al., 2018, 2024).

Many of the dynamic risk factors for domestic violence are likely to have developed from, or been exacerbated by, adverse childhood experiences (Burke et al., 2023; Capaldi et al., 2012; Gerstenberger et al., 2019; Kaukinen, 2014; Lee et al., 2022). Past trauma is one factor that can contribute to difficulties in developing the emotional regulation, interpersonal, and self-regulation skills that are protective against domestic violence (Capaldi et al., 2012; Gilchrist et al., 2017; Marotta, 2022; Taft et al., 2016). For LGBTQ+ individuals, research has also shown that unique minority stressors are a factor that can contribute to emotion regulation and self-regulation difficulties (Callan et al., 2021; Rolle et al., 2018). Social learning, social structure, and trauma-informed models of domestic violence perpetration provide frameworks for conceptualizing how earlier life experiences can contribute to patterns of coercive and abusive behavior (Li, 2022). Although past adversity and trauma may not be fully addressed in domestic violence offender treatment, the intention is that participants can recognize how these experiences may have influenced offending via dysfunctional coping and be able to use appropriate coping strategies to manage stressors in non-violent ways.

Antisocial associates and poor use of leisure time are two significant criminogenic needs identified within the RNR model (Bonta & Andrews, 2024), and studies with domestic violence offenders have found that these needs are present at a high rate (Hilton & Radatz, 2018; Stewart & Powers, 2014). Evidence has also emerged that tolerance and acceptance of intimate partner violence among household members and other social networks strongly influence individual attitudes toward domestic violence (Tracy et al., 2023). In contrast, positive social support, prosocial leisure activities, prosocial networks, and stable living circumstances are protective factors against domestic violence (Burghart et al., 2023; de Vogel et al., 2012; Spencer et al., 2022).

Survivor Impact and Community Safety

Four core competencies were developed that focus explicitly on increasing understanding and respect for survivor impact and community safety, namely:

> **Competency 8**: Demonstrate insight about the impact of their domestic violence offense on all individuals and promote victim empathy when clinically indicated.
>
> **Competency 9**: Increase understanding of how intergenerational patterns of family, peer group, community, and culture can normalize domestic violence and foster attitudes and responses that condone and tolerate domestic violence.
>
> **Competency 10**: Develop and implement safety plans to address risk factors and potentially high-risk situations.
>
> **Competency 11**: Cooperate with supervision requirements, court orders, and the terms and conditions.

The impacts of domestic violence are significant and include both short-term and long-term physical, psychological, and social health consequences for the victim, children, and other family members (Hamel et al., 2023; Holmes et al., 2022a, 2022b; Lafontaine et al., 2018). Research suggests that a lack of empathy may contribute to the risk of domestic violence (Godfrey et al., 2020), while the presence of empathy may act as a protective factor (Spencer et al., 2022). Recognizing and understanding the impact of abuse may be an important part of treatment, leading to reduced recidivism in some cases (Blatch et al., 2016; Dheensa et al., 2022; Holtrop et al., 2015). However,

promoting empathy to motivate change or reduce violence may not work for clients with low empathy capacity, especially those with psychopathy (Blais et al., 2022; de Ruiter & Hildebrand, 2022).

In group treatment settings, which are preferred for domestic violence offender programs, addressing one's past domestic violence may involve elements of shame management, consistent with the concept of reintegrative shaming (Ahmed et al., 2001; Braithwaite, 1989; Tagney et al., 2011). Reintegrative shaming consists of helping individuals understand the impact of their actions on victims, the community, and themselves while supporting positive changes and personal growth (Jonas et al., 2022). Loeffler et al. (2010) found that integrating a shame transformation process in domestic violence offender treatment resulted in enhanced self-esteem and empathic concern, which may strengthen treatment engagement as well as address criminogenic needs (McGinn et al., 2017; Romero et al., 2019). Other studies have shown that participants benefited from being held accountable for their behavior by others in the group (Holtrop et al., 2017; McGinn et al., 2020; Morrison et al., 2018, 2024) or through the inclusion of a community restorative justice program alongside standard domestic violence offender treatment (Mills et al., 2013).

A large body of research has examined the processes contributing to the intergenerational transmission of violence. One line of research has shown that exposure to violence in the family of origin is associated with learning attitudes accepting of domestic violence (Copp et al., 2019). Other research has shown that social-cultural attitudes promoting sexism and the acceptability of violence in social relationships are significant correlates of intimate partner violence across a wide range of countries (Herrero et al., 2017). Social learning theory connects these types of early learning experiences to subsequent adult domestic violence through the acquisition of behavioral scripts for violence and attitudes accepting of or promoting violence. Cognitive-behavioral treatments, which emphasize the role of learning and achieving change by addressing thought patterns and skill acquisition, have shown success in reducing domestic violence recidivism (Gannon et al., 2019; Miller et al., 2013; Travers et al., 2021).

Safety plans are a typical component of offender treatment programs as they help participants identify ways of safely avoiding and managing higher-risk situations (Bell, 2019). Research on offender safety plans in domestic violence treatment programs emphasizes the role these plans play in reducing recidivism and enhancing accountability. Research suggests that these support the offenders in recognizing triggers and contribute to victim safety by reducing immediate risks (Eckhardt et al., 2014; Mills et al., 2013). If well-constructed and tailored to a person's needs, a safety plan can provide individuals and their significant others with valid ongoing strategies for transitioning into and maintaining prosocial living (Bell, 2019). In addition, research consistently shows that increasing cooperation between offenders and their supervising officers (e.g., probation or parole officers) can reduce recidivism. Cooperation in this context often involves fostering positive relationships, increasing compliance with supervision conditions, and enhancing engagement in rehabilitative services (Bonta & Andrews, 2024; Lowenkamp et al., 2006).

Teletherapy for Domestic Violence Offender Treatment

The DVOMB allowed teletherapy as a treatment modality on March 13, 2020, in response to the COVID-19 pandemic. This decision aimed to ensure that the evaluation and treatment of domestic violence offenders could continue through teletherapy to reduce the risk to victims and community safety. Teletherapy was prohibited before this date, and treatment had to be conducted in person.

The *Standards and Guidelines* for treating domestic violence offenders have continued to permit teletherapy as an ongoing option as the field transitions to a post-pandemic normal. However, in-person therapy is still the preferred and expected treatment modality. *Appendix I* in *the Standards and Guidelines* outlines when teletherapy may be used, which includes the requirement for Approved Providers to have specific telehealth approval and to use teletherapy only when it is suitable for meeting a client's needs.

As per Appendix I,

> The provision of services via teletherapy is considered to be a privilege that is intended to promote risk-reduction strategies and engagement in the therapeutic process for the client. If the use of teletherapy presents any unresolved concern(s) related to the safety of a victim, the client's compliance with the treatment contract, or their overall amenability, the Approved Provider shall document such reasons and determine if face-to-face services are more appropriate. Offenders may be subject to additional monitoring as a result of being allowed to engage in domestic violence offender treatment via teletherapy.

The appropriate use of teletherapy for treating domestic violence offenders has been a topic of discussion at DVOMB meetings and among stakeholders. Issues raised include levels of client engagement, flexibility for clients to switch to in-person treatment, monitoring of client sobriety, and victim safety issues. To better understand the use of teletherapy, the DVOMB Application Review Committee (ARC) requested a research project on the use of teletherapy with domestic violent offender clients. The project had two components: an updated literature review on teletherapy effectiveness and an analysis of DVOMB provider data on the use of teletherapy provided under the *Standards and Guidelines*. This section summarizes the main findings, with the full policy brief available from the DVOMB on request.

Literature Review: Telemental Health Therapy Effectiveness

The use of teletherapy for mental and behavioral health treatments has significantly advanced since the COVID-19 pandemic. However, there is still a limited understanding of its effectiveness as a modality for offense-specific therapies, such as those for domestic violence offenders. Significant differences exist between mental health and offense-related treatments and the clients who attend them, which limits applying the findings from one to the other. Unlike mental health therapies, offense-related treatments are usually mandated, conducted in a group setting, delivered over more extended periods, and prioritize the safety of victims. Furthermore, individuals within the justice system often enter treatment with multiple criminogenic needs and responsivity factors that significantly impact their level of engagement in treatment and which may be exacerbated in virtual treatment modalities.

A literature review of evaluation research on the effectiveness of teletherapy found several recent meta-analyses that examined teletherapy for mental health symptoms. Meta-analyses combine results from multiple studies to show an overall finding. The meta-analyses found that teletherapy was as effective as in-person treatments in improving various mental health symptoms, with the most substantial evidence for cognitive-behavioral treatments of anxiety, depression, and post-traumatic stress disorder (Batastini et al., 2020, 2021; Fernandez et al., 2021; Lin et al., 2022).

DVOMB Provider Data Management System (PDMS) Teletherapy Data

The DVOMB PDMS was implemented in January 2023 as required by §16-11.8-103(4)(a)(IV), C.R.S. Approved Providers submit information on client treatment at the time-of-service completion, regardless of the outcome of the service. Data from January 1, 2023, to January 23, 2024, was available to analyze the use of teletherapy with domestic violence offender clients. A total of 1,448 client records were included, each containing information about a completed domestic violence offender treatment episode, irrespective of the type of discharge. Each record included the treatment modalities used, with the option to indicate multiple modalities where this occurred. The modalities included were:

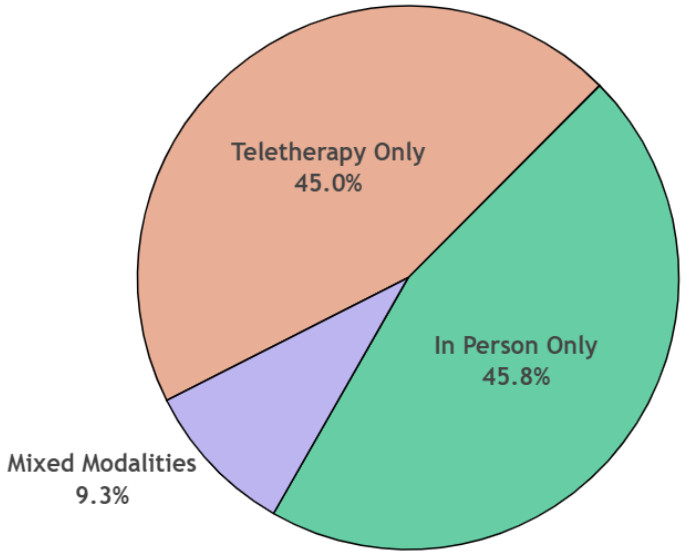
- In-Person Group Treatment
- In-Person Individual Treatment
- Teletherapy Group Treatment
- Teletherapy Individual Treatment
- Teletherapy for Medical or Weather-Related Emergencies

Per the specifications outlined in the *Standards and Guidelines*, group therapy is the preferred modality, while individual therapy can be utilized on a case-by-case basis. Thus, different combinations of treatment modalities are possible.

Figure 1 shows the percentage of clients who received treatment through different modalities: teletherapy only, in-person only, or a hybrid of both (i.e., mixed modalities). The data shows an equal distribution between those who used teletherapy exclusively and those who used in-person exclusively, with just under 10% of the sample having a mixed approach.

Among clients who received treatment exclusively in teletherapy, the majority participated in group sessions only (count 529; 37% of the total sample). A smaller number had a combination of teletherapy group and individual sessions (count 107; 7% of the total sample), while few had individual sessions alone (count 15; 1% of the total sample). Similarly, among clients who received treatment exclusively in-person, most attended group sessions only (count 535; 37% of the total sample). A smaller number had a combination of group and individual sessions (count 101; 7% of the total sample), while few had only in-person individual sessions (count 27; 2% of the total sample).

Figure 1. Treatment Modality Combinations 1/1/23–1/23/24 (Count 1,448). For the data table, see Appendix A.

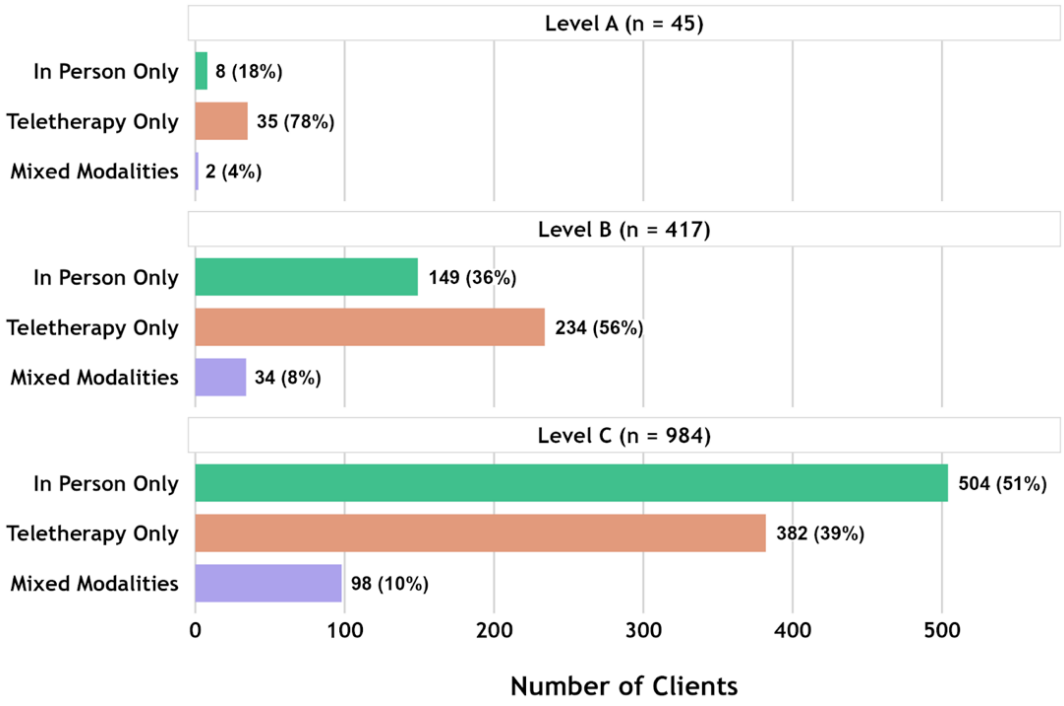


Key Findings

Trends in Use: Treatment Placement Levels for Teletherapy

Figure 2 displays the use of different treatment modalities by client treatment placement levels. Client treatment placement level is determined by the risk level assigned during evaluation using the Domestic Violence Risk Need Assessment (DVRNA). The treatment placement level determines the extent of treatment contact, required components, and general duration of treatment. Three levels are possible: Level A (low-risk), Level B (moderate-risk), and Level C (high-risk). As shown, teletherapy treatment was used more often with Level A (low-risk) and Level B (moderate-risk) clients than with Level C (high-risk) clients. The opposite was true for in-person treatment, which suggests risk was a factor in deciding treatment modalities.

Figure 2. Distribution of Treatment Modalities by Treatment Level Placed 1/1/23–1/23/24. For the data table, see Appendix A.

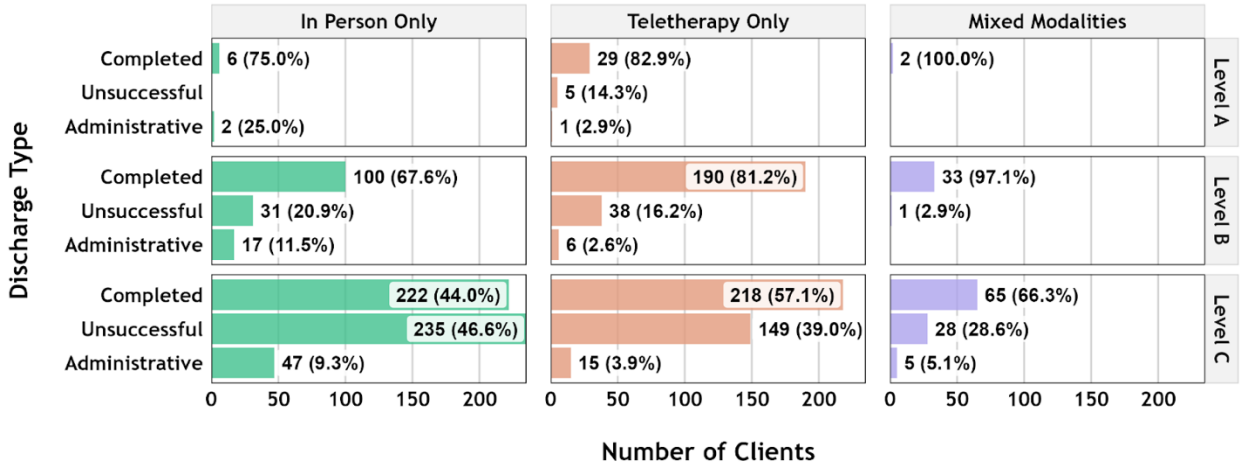


Completion Rates: Discharge Outcomes for Teletherapy by Treatment Level

Figure 3 displays client discharge outcomes based on the treatment modality received and the clients' treatment placement level. The *Standards and Guidelines* outline three treatment discharge types: completed treatment, unsuccessful, and administrative. As shown, teletherapy treatment was associated with higher completion rates and fewer unsuccessful discharges than in-person treatment. However, this was partly due to a higher proportion of Level C (high-risk) clients receiving in-person treatment. Additionally, the mixed modality approach was more effective, although this finding was not significantly different due to having a smaller sample size, making the result less reliable.

Further analysis of the different combinations of group and individual treatment sessions, not reproduced here, found that a combined approach of group and individual treatment, whether in-person or through teletherapy, had a significantly higher percentage of completed discharges for Level C (high-risk) clients than group treatment alone. A possible reason is that these options foster a better therapeutic relationship between the therapist and the client, resulting in greater engagement.

Figure 3. Discharge Outcome by Treatment Modalities and Risk Level 1/1/23–1/23/24. For the data table, see Appendix A.

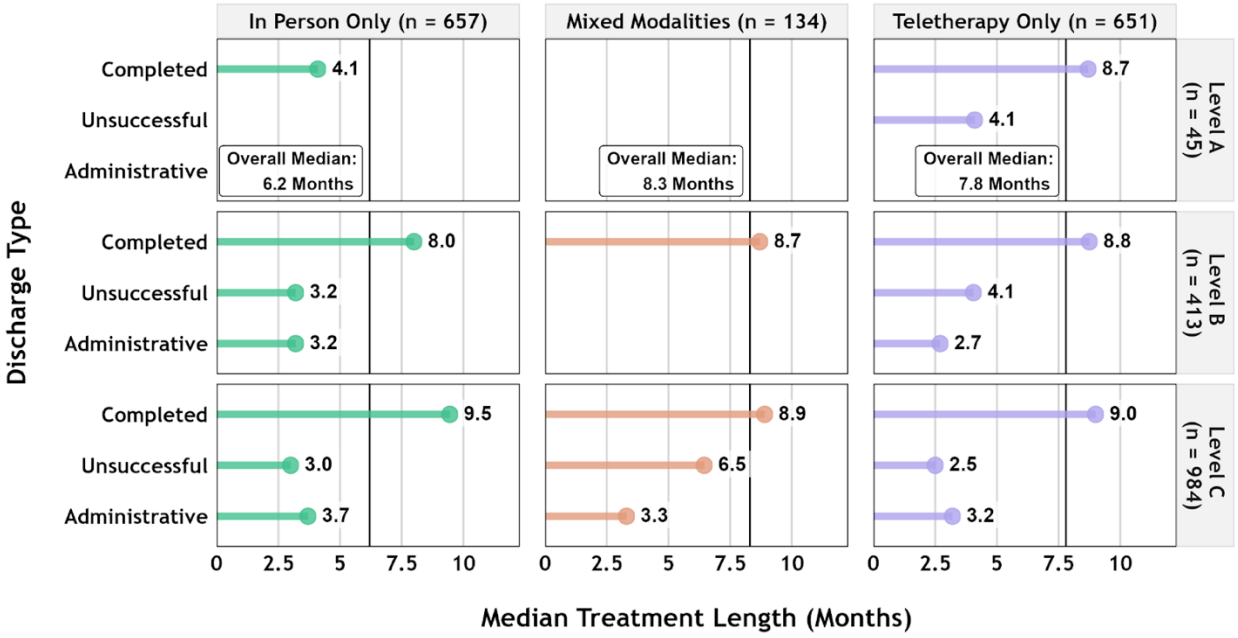


Treatment Duration: Length of Treatment Stay for Teletherapy by Treatment Level

Figure 4 displays the median treatment length based on the treatment modality received and the clients' treatment placement (risk) level. The length of time clients spend in treatment is determined by their level of risk and the type of treatment they require. As each treatment level has specific requirements that must be achieved before the treatment is finished, clients with lower risk levels typically have shorter treatment periods, while higher-risk clients may have longer treatment durations. However, since clients have personalized treatment plans and progress at different rates, each treatment level has no fixed length.

As shown in **Figure 4**, although the median length of treatment for teletherapy and mixed modalities was longer than for in-person treatment, this was due to Level A (low-risk) clients spending longer in teletherapy and Level B (moderate-risk) clients spending longer in mixed modalities before unsuccessful discharge. Level B (moderate-risk) and Level C (high-risk) clients with completed discharges had similar treatment lengths regardless of modality.

Figure 4. Median Treatment Length by Modality Type, Treatment Level, and Discharge Type 1/1/23–1/23/24. For the data table, see Appendix A.



Appropriateness: DVRNA Risk Factors Associated with Teletherapy Unsuccessful Discharge

Statistical modeling was used to examine the DVRNA risk items associated with unsuccessful discharge from teletherapy. The DVRNA includes 14 risk domains containing 46 individual risk items and is completed during evaluations. The final model identified several key factors:

- Level C (high-risk) treatment placement
- Explicit pro-domestic violence attitudes
- Illegal drug use
- Substance use
- On supervision when offended
- Prior non-domestic violence convictions
- In need of mental health evaluation
- Less than a high school diploma
- Younger age

Additional analysis found that a history of violating the conditions of release and implicit attitudes supporting domestic violence were associated with unsuccessful discharge from teletherapy within the first 3 months of treatment.

Research Insights and Implications

Research demonstrating the effectiveness of teletherapy for mental and behavioral health treatments supports the DVOMB's decision to continue allowing teletherapy for the delivery of domestic violence offender treatment. However, the lack of research on its effectiveness with offense-specific treatment in general and domestic violence treatment in particular indicates continued caution is still necessary. The current guidelines, as outlined in *Appendix I* of the *Standards and Guidelines*, permit teletherapy to be used by Approved Providers with telehealth approval and when suitable for meeting a client's needs. The guidelines indicate that in-person therapy continues to be the preferred and expected treatment modality.

Implementation of the DVOMB PDMS has made it possible to examine the use of teletherapy for domestic violence offender treatment delivered under the purview of the DVOMB. The current data analysis project shows that this data can help shape best practices and future revisions to the *Standards and Guidelines*. The project encompassed 1,448 client records over a year, providing insight into teletherapy use by client placement (risk) level, discharge outcome, and length of treatment. It also looked at DVRNA risk factors that were predictive of unsuccessful discharge. However, a limitation at this stage is that client recidivism outcomes from teletherapy were unavailable in this project due to insufficient time post-discharge to capture a reliable estimate of the recidivism rate.

A key finding was that teletherapy is used at a relatively high rate for domestic violence offender treatment delivery, on par with in-person treatments. In total, 45% of clients received domestic violence treatment exclusively through teletherapy. It was observed that teletherapy was more often used with clients identified as low and moderate risk rather than high risk, suggesting that the client's risk level was considered in the decision to offer teletherapy. However, it was still the only treatment modality used in 39% of the high-risk cases. Given the lack of research on outcomes and questions about the fidelity of teletherapy for offender treatment, this rate of use warrants continued monitoring and scrutiny. Additionally, the finding that high-risk (Level C) status, a more extensive history of antisocial behavior and criminality, acute mental health needs, and low educational attainment were predictors of unsuccessful discharge from teletherapy suggests that it is not a suitable first choice for clients with those characteristics.

Another key finding was that a significant proportion of clients who received teletherapy were successfully discharged as having completed domestic violence offender treatment. In fact, discharge outcomes from teletherapy performed marginally better over in-person treatment when controlling for risk but less so than mixed modalities. Without having further data on treatment fidelity or recidivism rates, it is impossible to evaluate whether successful completion of teletherapy is equivalent to successful completion of in-person or mixed modality treatment and the degree to which it leads to sustained behavioral change and reduced recidivism. These limitations question how aspects of teletherapy, such as ease of attendance or less intense participation requirements in an online modality, make it easier to complete treatment devoid of evidence of long-term implications to victim safety. It was also observed that a combined approach of group and individual treatment for high-risk (Level C) clients, whether through teletherapy or in-person treatment, led to a significantly higher

percentage of completed discharges than group treatment alone. This suggests that including some individual therapy contact fosters a better therapeutic relationship and results in greater engagement.

A final key finding was that clients at moderate (Level B) and high (Level C) placement levels spent similar lengths of time in treatment before discharge, regardless of treatment modality. It is important to note that within those treatment durations, the higher-risk clients would have had a greater intensity of treatment contacts than the lower-risk clients following the requirements of the S*tandards and Guidelines*. In contrast, low-risk (Level A) clients spent longer in teletherapy than in-person therapy. While reassuring that teletherapy treatment length is on par with in-person treatment and not shorter, understanding the optimum treatment length for each treatment modality requires examining the impact of these on recidivism rates in future research.

The DVOMB ARC established a working group to examine the results of the teletherapy project and other insights gathered about teletherapy best practices from the DVOMB Standards Compliance Reviews (SCRs). The working group's goal is to improve the guidelines for teletherapy and consider setting more specific eligibility requirements as a treatment method until further recidivism research is available. This initiative aims to ensure that teletherapy remains a viable option for clients when needed, often due to limited service availability in rural areas, while being used in the most effective way to engage domestic violent offender clients and promote victim and community safety.

DVOMB Data Analysis

Data Collection Overview

The Colorado Legislature passed House Bill 22-1210 in June 2022, which reauthorized the DVOMB and mandated the Board to develop a data collection plan that required Approved Providers to begin data collection no later than January 1, 2023. Following the bill's passage, the Board presented a proposal for a data collection plan to the DVOMB that was approved in September 2022.

The data collection plan offers two options for DVOMB Approved Providers to submit client-level data at the time of discharge. The first is through the PDMS, which is a governmental electronic record system developed by the Colorado Department of Public Safety and administered by the DVOMB program staff. The second is through ReliaTrax, a privately operated electronic health record management system to which a majority of DVOMB providers subscribe.[1] Given the high subscription rate, the DVOMB partnered with ReliaTrax to integrate the data collection requirements to avoid duplicate data entry efforts. Between October and December 2022, the DVOMB and ReliaTrax held training on the new mandate, data collection procedures, and the process for obtaining a research release from clients.

Data collection began on January 1, 2023. As DVOMB Approved Providers implement this new requirement, ongoing technical assistance for data collection has been offered.[2] DVOMB Approved Providers submit data for each treatment episode for each individual client. The DVOMB analyzes the data and presents findings in aggregate form. Individual provider data or outcomes cannot be isolated.

[1] At the time the data collection plan was developed, 75% of the DVOMB Approved Providers were subscribers of ReliaTrax.

[2] These efforts have included outreach by the DVOMB ARC to providers who have not submitted data to ensure understanding of the requirements.

The data analyzed for this report combines records from the PDMS and ReliaTrax into a single dataset. The data included in the report align with the Colorado State Fiscal Year 2024 and were submitted between July 1, 2023, and June 30, 2024. The current reporting period represents the first full year of data collection and is referred to as Year 1.[3] Data previously reported for the first six months of data collection in the DVOMB 2024 Annual Legislative Report is referred to as Year 0 or the Implementation Phase.

Background and Client Characteristics

For the 12-month period running July 1, 2023 to June 30, 2024, Approved Providers submitted 2,017 client records. The PDMS was used for 164 records (8%), while ReliaTrax was used for 1,1853 (92%). A small number of records were removed from analysis as they related to clients who were not under the purview of the DVOMB, either due to being under 18 years old at the time of their offense or voluntary self-referrals. The final dataset contained 1,994 client records. The amount of data submitted was significantly greater than expected based on the 437 records submitted for the six-month implementation phase (Year 0). The records contained clients from 21 of the 23 Judicial Districts in Colorado, an increase from the 16 districts represented in the previous year's six-month implementation phase (Year 0).[4] This past year (Year 1), clients from El Paso, Arapahoe, Weld, and Larimer counties had the greatest number of records.

Over three-quarters of the clients (78%) consented to share their personal identifying information for future recidivism tracking. This substantially increased from the 47% reported in the previous year's six-month implementation phase of data collection (Year 0).

Table 1 displays the demographic characteristics of clients seen in FY 2024. Most clients were male, while 20% were female. The average age was 34, ranging widely from 18 to 89. Most clients identified as heterosexual, while 4% identified as having other sexual orientations. Over three-quarters of the clients had a high school diploma or higher educational qualification, but a relatively small proportion had college-level diplomas or degrees. Client race-ethnicity was 53% White and 47% BIPOC. Hispanic-Latino clients comprised 32%, while Black or African American clients comprised 9%.[5] Other racial-ethnic groups accounted for 6%. It is important to note that this data does not fully represent information about individuals identifying as multiple racial or ethnic groups, as data entry is limited to selecting one category rather than multiple. English was the primary language spoken by most clients, followed by Spanish.

[3] The DVOMB 2024 Annual Legislative Report presented data from the first six months of 2023, from January 1, 2023, to June 30, 2023. This is referred to as Year 0 or Implementation Phase.

[4] No data was entered for clients from the 3rd or 7th Judicial Districts.

[5] Of the 622 clients who responded, 78% identified Mexican origin.

Table 1: Client Demographics FY 2024. For screenreader accessible table, see Appendix A.

Client Characteristic (N = 1,994)	n (%) / Mean (Range)
Gender	
Male	1,606 (81%)
Female	385 (19%)
Non-Binary	*
Transgender Male	*
Sexual Orientation	
Heterosexual	1,921 (96%)
Bisexual	24 (1.2%)
Gay	24 (1.2%)
Lesbian	15 (0.8%)
Self-identify	5 (0.3%)
Pansexual	*
Asexual	*
Questioning	*
Race/Ethnicity	
White	1,010 (53%)
Hispanic	614 (32%)
Black or African American	165 (8.7%)
Native American or American Indian	43 (2.3%)
Latino	32 (1.7%)
Asian or Pacific Islander	22 (1.2%)
Not listed here	16 (0.8%)
Missing	92
Hispanic Origin	
Not Hispanic Origin	1,066 (63%)
Mexican	485 (29%)
Not Listed Here	110 (6.5%)
Puerto Rican	16 (0.9%)
Latino	11 (0.7%)
Missing	306
Age (At Time Of Offense)	34 (18 - 89)
Primary Language	
English	1,555 (92%)
Spanish	130 (7.7%)
Mandarin	*
Not listed here	*
Missing	306
Highest Education (At Time of Offense)	
High school degree or equivalent (e.g., GED)	940 (56%)
Less than high school degree	394 (23%)
Bachelor degree	113 (6.7%)
Associate degree	101 (6.0%)
Vocational schooling	91 (5.4%)
Graduate degree	31 (1.8%)
Some college but no degree	14 (0.8%)
Doctoral degree	*
Missing	306

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

Regarding clients' relationship status with the victim of their index domestic violence offense:

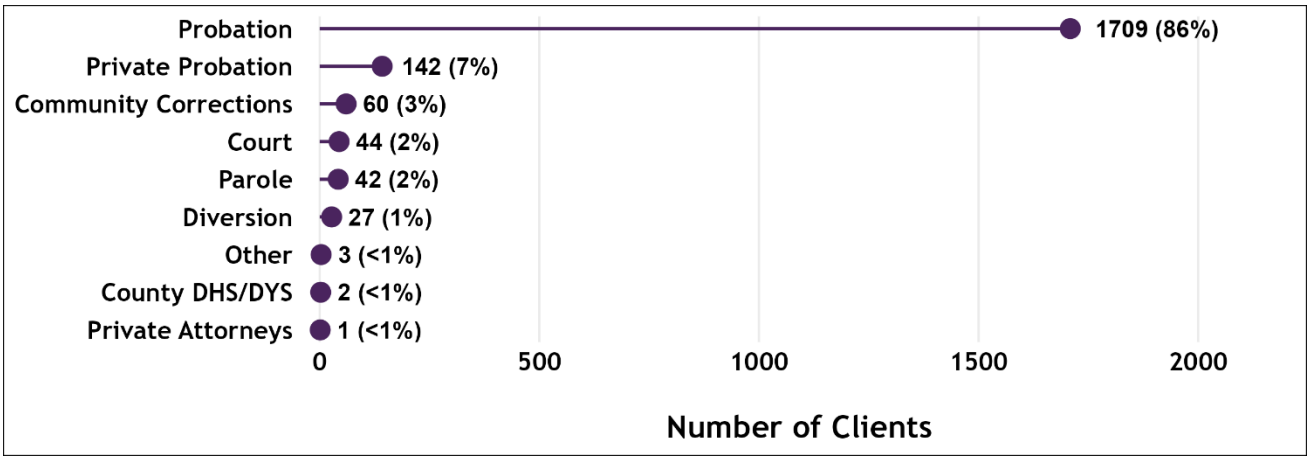
- 29% were separated
- 28% were formally married or in a common-law marriage
- 24% were in an exclusive relationship
- 18% were dating
- <1% were in an open relationship
- <1% were formally divorced

Regarding clients' prior convictions for domestic violence and prior domestic violence treatment:

- 29% had prior domestic violence convictions
- 32% had prior domestic violence incidents not reported to the justice system
- 26% had violations of an order of protection
- 12% had past/present civil domestic violence-related protection orders
- 16% had prior arrests for domestic violence
- 24% had prior domestic violence treatment

Additionally, 12% of clients were sentenced to unsupervised probation before starting domestic violence offender treatment, compared to 5% in Year 0. **Figure 5** shows the referral sources for clients attending domestic violence offender treatment. As shown, probation referred most clients.

Figure 5: Number of Domestic Violence Treatment Clients by Referral Source FY 2024 (Count 1,994)*. For the data table, see Appendix A.



*Percents do not add up to 100% as multiple referral sources may be selected for each client.

Assessment and Evaluation Variables

The data indicated that 92% of clients had an evaluation completed by the Approved Provider within 30 days of receipt of the referral. The types of documents used during the evaluation were:

- Law Enforcement Summary Reports (97%)
- Criminal History (82%)
- Victim Statements (30%)
- Previous Domestic Violence Offender Evaluations (5%)
- Substance Abuse Evaluations (5%)
- Mental Health Records (4%)
- Other Documents (7%)

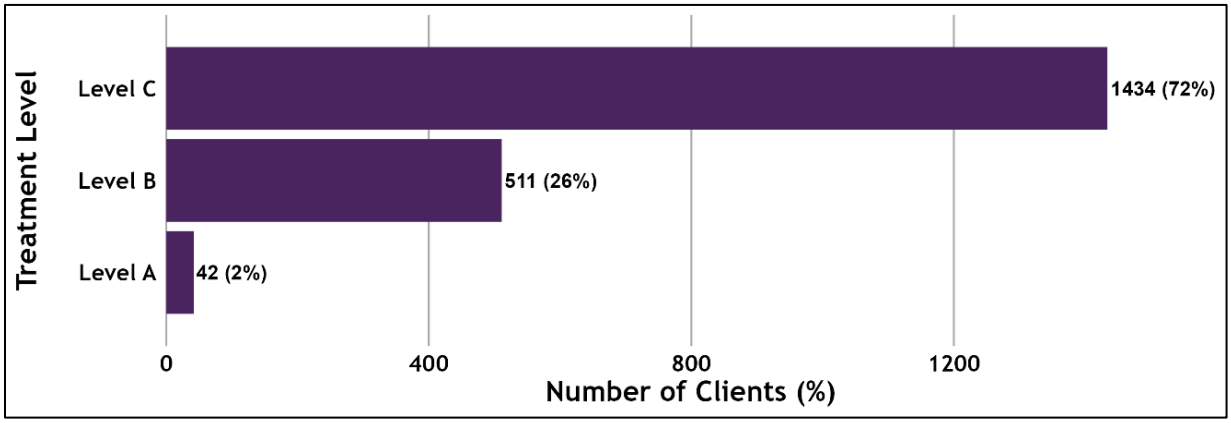
When receiving treatment, domestic violence offenders are placed into one of three placement levels, which correspond to the intensity of treatment. To determine the placement level, the Approved Provider scores the DVRNA instrument following client interviews and reviewing collateral document sources. The DVRNA was developed to apply the risk and need principles of the RNR model to domestic violence offenders. It aligns treatment placement and intensity to the risk and needs evident for the clients.[6]

The DVOMB Approved Provider consults with the MTT regarding the DVRNA results when determining the appropriate treatment level. The MTT comprises the DVOMB Approved Provider, the supervising agent, and a treatment victim advocate. This team collaborates to 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 they are in treatment.

As shown in **Figure 6**, the majority of clients are placed in Level C, the highest-intensity treatment placement. The remaining clients are predominantly placed in Level B, the moderate intensity option, while very few are suitable for Level A, the lowest intensity option. Additional data also indicated that most clients (81%) maintained the same treatment level through therapy. Treatment levels decreased for 17% of clients and increased for < 2%.

[6] A fuller description of the DVRNA and its validity as a treatment placement tool can be found in last year's DVOMB 2024 Annual Legislative Report.

Figure 6: Distribution of Treatment Levels Placed for Colorado DV Treatment Clients FY 2024 (Count 1,987). For the data table, see Appendix A.



Level B and Level C treatment placements require that clients have a second contact with their provider and/or adjunct treatment to address substance abuse, mental health needs, or skills deficits. Data about these second contacts indicated clients were referred for the following services:

- 43% for mental health treatment
- 37% for substance abuse treatment
- 22% for an unspecified second contact
- 10% for Moral Reconation Therapy (MRT)
- <1% for Eye Movement Desensitization and Reprocessing (EMDR).

Responsivity Factors

Responsivity factors are characteristics of the individual that affect how they respond to the intervention.[7]

Approved Providers assessed responsivity factors through the therapeutic alliance (48%), client feedback (71%), collateral contacts (55%), and identifying the topic of treatment sessions (41%).

Approved Providers identified the following responsivity barriers during treatment:

- Client Factors (25%)
- Finances (20%)

[7] 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.

- Lack of Social Supports (7%)
- Adjunct Treatment Needs (5%)
- Employment Factors (4%)
- Cultural Needs (4%)
- Housing Issues (3%)
- Terms of Supervision (3%)
- Lack of Engagement with the Community (3%)
- Terms of Supervisions (3%)
- Community Limitations (2%)
- Transportation (2%)
- Lack of Specific Resources (1%)
- Other (2%)

Approved Providers reported addressing clients' responsivity factors by:

- Offering Vouchers (22%)
- Adjusting Treatment Modalities (10%)
- Adjusting Treatment (8%)
- Using External Supports (5%)
- Adjusting Treatment Language (4%)
- Adjusted Treatment for Culture (2%)
- Using Specialized Resources (2%)
- Providing Housing and Transportation Support (1%)
- Using Other Supports (1%)

Treatment Outcomes

The *Standards and Guidelines* require the MTT to reach a consensus regarding the client's 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:

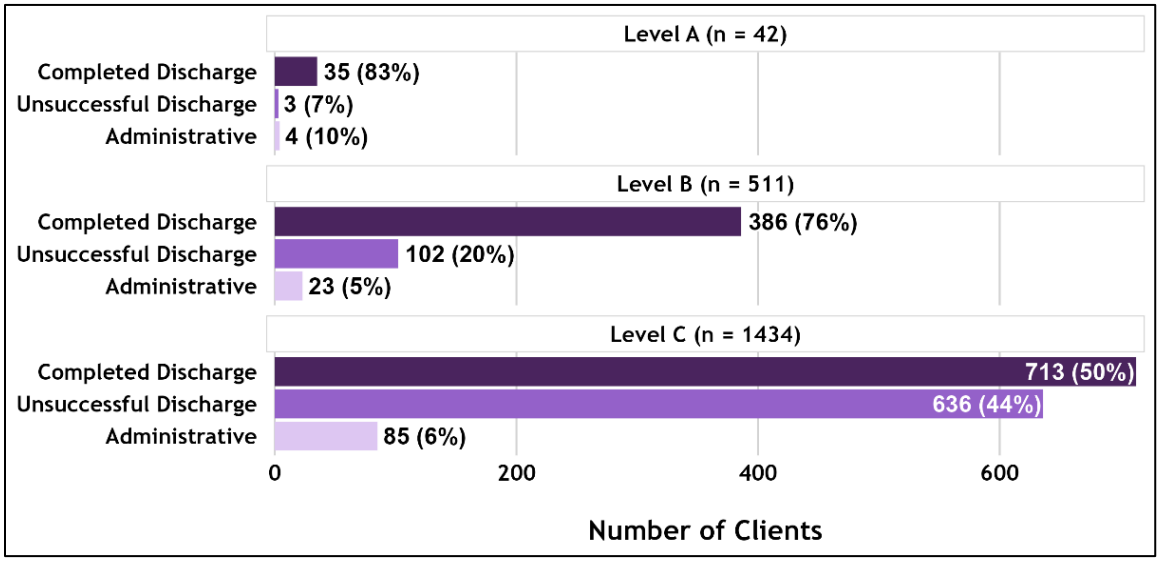
- Has progressed and addressed the core competencies.
- Has completed the required minimum number of treatment plan reviews.
- Has no additional risk factors.
- Has met the requirements and conditions of their treatment plan.

A client who receives an unsuccessful discharge indicates that the MTT agrees that the client lacked progress related to the core competencies, had compliance issues with the offender contract or treatment plan, or was engaging in risk-related behaviors. If a client has circumstances 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 clients with discharge outcome information reported, 57% had completed discharges (compared with 62% in Year 0), 37% had unsuccessful discharges (compared with 30% in Year 0), and 6% had administrative discharges.

As displayed in **Figure 7**, rates of successful treatment completion increase as the corresponding risk decreases by treatment level. Clients in treatment Level A had the highest percentage of completed discharges at 83%. Clients in treatment Level C had the lowest completed discharge rates at 50%. The significant difference in successful completion rates observed among Level C clients is likely influenced by their higher risk levels and greater density of criminogenic needs. This is congruent with research that indicates higher-risk individuals tend to present more challenges for treatment retention and completion than those with lower-risk levels.

Figure 7: Discharge Outcomes by Treatment Level Placed for Colorado DV Treatment Clients FY 2024 (Count 1,987). For the data table, see Appendix A.



Approved Providers are required to indicate at least one discharge reason for each treatment client, regardless of treatment outcome. **Table 2** presents the discharge reasons indicated for clients with unsuccessful discharges. A discharge reason involving excessive absences was indicated for 11% of clients (compared with 25% from Year 0). Of note, 6 clients had non-compliance with monitored sobriety/drug alcohol use, 4 had new domestic violence-related offenses, 3 never attended, 3 violated the terms of conditions of supervision, 1 committed a new non-domestic violence offense, and 1 dropped out due to inability to meet financial responsibilities.

Table 2: Discharge Reasons for Colorado DV Treatment Clients with Unsuccessful Discharges FY 2024 (Count 741)

Discharge Reason	Number of Clients	Percent of Clients (%)
Administrative—Other	465	63%
Unsuccessful—Excessive Absences	111	15%
Unsuccessful—Other	87	12%
Unsuccessful—Dropped out of Program/Abandoned Treatment	13	2%
Unsuccessful—Non-Compliance with Monitored Sobriety/Drug Alcohol Use	6	1%
Unsuccessful—New domestic violence-related offense	4	1%
Unsuccessful—Never Attended/Failed to Begin Program	3	<1%
Unsuccessful—Violation of terms and conditions of supervision	3	<1%
Unsuccessful—Unable to meet financial responsibilities	2	<1%
Unsuccessful—Violation of Treatment Plan/Contract	1	<1%
Unsuccessful—New non-domestic violence-related offense	1	<1%

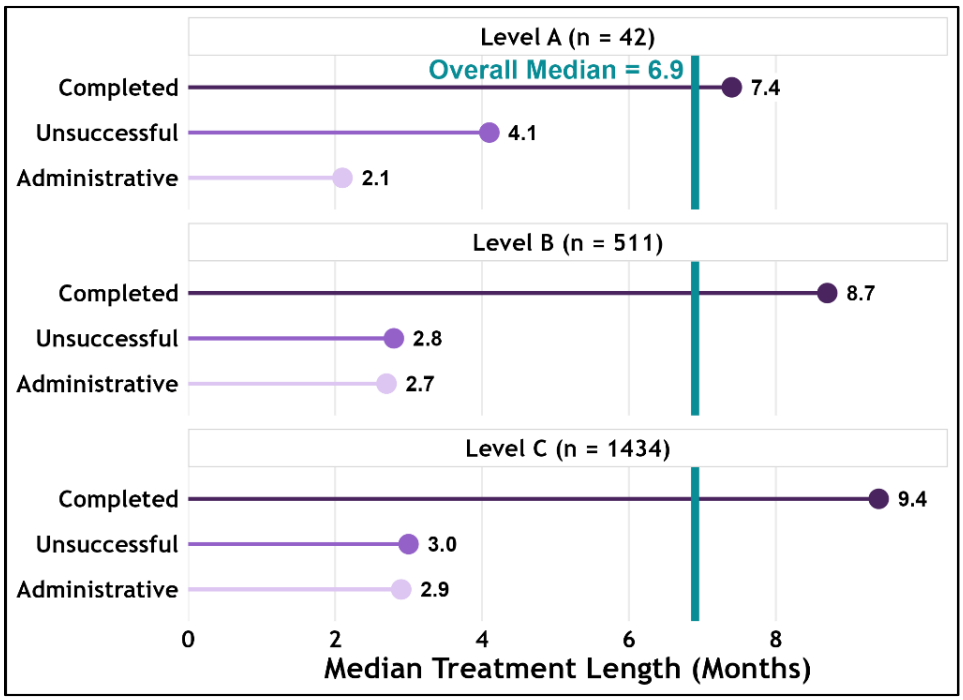
Treatment Duration

Treatment duration ranged from 0 to 36 months (3.03 years). The median duration in treatment was 6.9 months across all discharge types, indicating that 50% of the clients spent less than 6.9 months in treatment and 50% spent more than 6.9 months in treatment.

Figure 8 displays the median treatment length by treatment level. Across all three placement levels, the median treatment length for clients with a completed discharge was 9 months, indicating that 50% of clients who successfully completed treatment spent 9 months or longer in treatment. The median treatment length for unsuccessful discharges was 3 months, indicating that 50% of clients who were unsuccessfully discharged spent less than 3 months in treatment. It appears likely that for many of those clients, attendance problems were an issue, suggesting no or minimal engagement in the treatment process for many clients who were ultimately unsuccessfully discharged from domestic violence offender treatment.

Level C clients who completed treatment had the highest median treatment length at 9.4 months, followed by Level B clients and then Level A clients. This result is consistent with research suggesting that higher-risk clients (i.e., those in treatment Level B and Level C) require a higher dosage and intensity of treatment to address co-occurring issues as mandated by the *Standards and Guidelines*. In contrast, those who were unsuccessfully discharged had a significantly shorter length of stay, with over half of those from Level B and Level C having 3 months or less before unsuccessful discharge.

Figure 8: Treatment Length for Colorado DV Treatment Clients by Treatment Level Placed FY 2024 (Count 1,987). For the data table, see Appendix A.



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 that 11.5% of clients did not miss any treatment sessions (compared with 13% in Year 0); 29% missed one to three times; and over half of clients (60%) missed four or more times with an average of seven absences. Excessive absences are a barrier to clients effectively engaging in the treatment process and represent a common challenge in this field.[8] Statistical analyses indicated that greater treatment absence was associated with higher risk levels, while fewer absences were associated with the use of hybrid in-person and teletherapy modalities.[9] While the *Standards and Guidelines* provide an allowance for excused absences,[10] excessive absences have been anecdotally reported as a problem for continuity and often lead to early terminations from treatment.

Treatment Modalities

As per the *Standards and Guidelines*, group treatment sessions are the preferred modality for domestic violence offender treatment, while individual sessions can be used on a case-by-case basis. In addition, in-person treatment is preferred over teletherapy unless it is in the client's best interests to have access to treatment virtually. In FY 2024, 45% of clients received in-person sessions only (group or individual sessions; compared to 54% in Year 0), 45% received teletherapy only (teletherapy group, individual teletherapy, or teletherapy for medical or weather-related emergencies; compared with 34% in Year 0), and 9% received mixed modes of both in-person and teletherapy (compared with 12% from Year 0). Specifically:

- 49% received in-person group therapy
- 12% received in-person individual sessions
- 52% received teletherapy group (compared with 44% in Year 0)
- 8% had individual teletherapy (compared with 15% in Year 0)
- < 0.5% had teletherapy for medical or weather-related emergencies.

Note that more than one treatment modality could be used for each client. However, among the providers, 80% reported using one modality only, and 19% reported using two to five modalities.[11]

[8] High rates of non-completion and drop-out from domestic violence offender treatment have been documented in many research reports (e.g., Murphy et al., 2020; Olver et al., 2011; Zarling et al., 2020).

[9] Chi-Square tests of association indicated Level A clients were significantly less likely to miss any treatment than Level B and Level C clients ($p<.001$). Mixed modalities were associated with reported significantly less client absences than in person only or teletherapy only modalities ($p<.001$).

[10] 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.

[11] 1% of clients had missing modality data.

Limitations

The DVOMB Data Analysis included in this report provides the first full year of data collection following the implementation of the data collection mandate. The data submission rate has increased from Year 0, although a few providers still need to enter data and some judicial districts are represented more than others. DVOMB program staff will continue offering training and technical assistance to resolve missing data issues and will review the relevance of missing data questions as part of the implementation process.

Summary and Conclusions

The DVOMB has gathered a significant amount of data in this report, showcasing the commitment of Approved Providers to support evidence-based research regarding the *Standards and Guidelines* and to maintain fidelity in their implementation. The data covers the first full 12-month period of the data collection (Year 1) and builds upon the initial 6-month implementation phase (Year 0) reported in last year's DVOMB 2024 Annual Legislative Report. Notably, the rate of client consent to release information for future recidivism research was high and reflected an increase from that reported for Year 0. This suggests a strong recognition of the value of evidence-based practices by both clients and providers.

The Year 1 data appears to be more representative of the clients seen for domestic violence offender treatment in Colorado under the purview of the DVOMB compared to the Year 0 data. This improvement can be attributed to several factors. First, Year 1 includes a 12-month reporting period, whereas Year 0 had only a 6-month reporting period. Second, Year 1 encompasses data from a greater number of judicial districts, with only a few still not represented. Third, there is a significantly higher volume of data in Year 1. Although a few providers have not submitted any data, the response has been relatively strong. Finally, the data collection process was still being refined during the first 6-month reporting period of Year 0, while it became well established in Year 1. As a result, the differences in percentages between Year 0 and Year 1 may reflect an improvement in the representativeness of the data rather than actual changes between the two periods. It will take additional years of data reporting to more accurately identify any true shifts in client demographics or treatment outcomes.

The PDMS offers DVOMB Approved Providers a way to track service provision, communicate any issues or concerns, and share successful strategies directly with the DVOMB. The data collection system includes comment boxes throughout the process, enabling Approved Providers to input comments and qualitative data. In Year 1, a substantial amount of text comments was entered, primarily regarding conviction types, discharge reasons, client and victim relationships, victim treatment advocacy services, and second contact recommendations. The DVOMB will review and qualitatively analyze this data when appropriate to inform revisions to *Standards and Guidelines*, enhance implementation processes, and provide training and technical assistance opportunities.

The *Standards and Guidelines* have established a differentiated treatment model based on the principles of Risk, Need, and Responsivity. Data collected during Year 1 suggests that Approved Providers follow these *Standards and Guidelines*. The comprehensive 12-month data provides a solid foundation for updating the *Standards and Guidelines* over time, using evidence to support future policy initiatives. The PDMS and the research capabilities derived from the data collected are unique in the United States and may facilitate meaningful changes in the policies and practices informing the treatment and management of domestic violence offenders.

Section 2: Relevant Policy Issues and Recommendations

Background

Pursuant to HB 22-1210, 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 in Colorado.

This report is a product of the 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 the Colorado Governor's Office, Office of State Planning and Budgeting, the Colorado Department of Public Safety, or other state agencies.

United States v. Rahimi and Firearm Restrictions

Federal statute under 18 U.S.C. 922(g)(8) prohibits an individual under an active domestic violence restraining order from possessing firearms. For decades, this prohibition has served as an important safety measure for victims and the primary method for restricting firearm access for those who have committed acts of domestic violence. The case of *United States v. Rahimi* recently examined this prevailing doctrine, challenging the constitutionality of this prohibition. The findings reinforce the constitutionality of enforcing appropriate firearm restrictions through protection orders and implementing red flag laws across the state when domestic violence offenders pose a risk to potential victims and the community.

The facts of this case involve Zackey Rahimi, his former girlfriend (hereafter the "victim"), and their minor child. In December 2019, Rahimi grabbed, dragged, and shoved the victim into his car after she attempted to leave. Rahimi proceeded to retrieve a firearm from under the passenger seat and discharged the weapon; it is uncertain whether Rahimi shot at the victim or a witness. The victim sought a restraining order following this incident and previous assaults, despite a threat by Rahimi when he later called and warned that he would shoot her if she reported the incident. A Texas state court granted a two-year restraining order against Rahimi, which prohibited him from threatening the victim or her family or contacting the victim except to discuss their child. The order suspended Rahimi's gun license for two years. The court made specific findings that Rahimi committed family violence and posed a "credible threat" to the physical safety of the victim and the child.

Rahimi violated the order within six months and threatened a different woman with a firearm, resulting in a charge for aggravated assault with a deadly weapon. Afterward, Rahimi was involved in

five shooting incidents between December 2020 and January 2021. In response, law enforcement obtained a search warrant to search Rahimi's residence where "they discovered a pistol, a rifle, ammunition, and a copy of the restraining order." Rahimi was indicted on one count of possessing a firearm while subject to a restraining order, in violation of 18 U.S.C. 922(g)(8). Rahimi challenged the indictment that prohibited him from possessing a firearm, arguing that the law criminalizing his conduct violated his Second Amendment rights and was therefore unconstitutional.

The Fifth Circuit Court of Appeals initially dismissed the challenge, citing a previous case that established the law as constitutional. However, this decision was later withdrawn and reconsidered after the Supreme Court decision in *NYSRPA v. Bruen*, which declared the firearm prohibition for individuals subject to qualifying domestic violence restraining orders unconstitutional.

The U.S. Supreme Court granted certiorari, and the case received national attention in anticipation of a ruling. Ultimately, the U.S. Supreme Court ruled in an 8 to 1 decision in *United States v. Rahimi* that "when an individual poses a credible threat to the physical safety of an intimate partner, such as those subject to a restraining order, the ban on possessing firearms is consistent with the 2nd Amendment."

Impact of Kayden's Law and Reunification Proceedings

In May 2023, Colorado enacted Kayden's Law through House Bill 23-1178, which sought to better protect children within the family legal system and to comply with the Keeping Children Safe from Family Violence Act. HB 23-1178 included many provisions:

- Requires courts that hear parental allocation proceedings involving domestic violence or child abuse, including child sexual abuse, to consider the admission of expert testimony and evidence if the expert demonstrates expertise and experience working with victims of domestic violence or child abuse. Courts are also required to consider evidence of past sexual or physical abuse committed by the accused party, any restraining orders against the accused party, arrests or convictions of the accused party, and any other documentation of abuse, such as letters to landlords to break leases or medical records.

- Prohibits a court from removing a child from or restricting contact between a child and a protective party who is competent, protective, not physically or sexually abusive, and with whom the child is bonded or attached solely to improve a deficient relationship with the accused party.

- Provides that a court shall not order reunification treatment (treatment) that is predicated on cutting off the relationship between a child and a protective party with whom the child is bonded and attached. If a court orders treatment, the treatment must be generally accepted and there must be scientifically valid proof of the safety, effectiveness, and therapeutic value of the treatment.

- Directs the task force created in House Bill 23-1108 to study victim and survivor awareness and responsiveness training requirements to make recommendations for any judge or magistrate who presides over parental responsibility proceedings.

- Requires child and family investigators, parental responsibilities evaluators, and legal representatives of children who do not contract with the office of the child's representative

(office) to complete initial and ongoing training on domestic violence and child abuse. A trainer with experience assisting survivors of domestic violence or child abuse is required to conduct the training.

- Requires the judicial branch to apply to the federal Department of Justice's Office of the Attorney General for a grant increase to comply with the federal act.

In the course of drafting HB 23-1178, the following additional provision was added to 14-10-127.5.(IV)(c), C.R.S.:

> (IV) If a court issues an order to remediate the resistance of a child to have contact with an accused party, the order must primarily address the behavior of the accused party, who shall accept responsibility for the accused party's actions that negatively affected the accused party's relationship with the child, and a mental health professional approved by the Domestic Violence Offender Management Board shall verify the accused party's behavior before the court orders a protective party to take steps to improve the relationship with the accused party.

The added provision stipulates specific actions by DVOMB Approved Providers related to reunification and reunification treatment in a civil proceeding where domestic abuse is alleged to be present. However, the family court system and this statute are outside the purview of the DVOMB. The DVOMB is charged with developing and implementing guidelines and standards with which providers must comply regarding the assessment, evaluation, treatment, and behavioral monitoring of offenders convicted of domestic violence. The DVOMB maintains a list of providers who have been approved to provide treatment to domestic violence offenders in the criminal legal system and not the family court system. The result is that these *Standards and Guidelines* were not developed to address the complexities of these cases or issues, nor are they appropriate for use in this context.

HB 23-1178 added new language requiring DVOMB Approved Providers to "verify the accused party's behavior before the court orders a protective party to take steps to improve the relationship with the accused party" in a civil court proceeding. Verification tethers the professional responsibility of the DVOMB Approved Provider to a high and impracticable standard that can expose DVOMB Approved Providers to liability and complaints, specifically in the absence of guidelines regarding evaluation methods, assessment measures, and reporting strategies that fall outside of the DVOMB's purview.

Recommendation

Amend the language in 14-10-127.5, C.R.S. to remove or modify the requirement for a DVOMB Approved Provider to "verify the accused party's behavior before the court orders a protective party to take steps to improve the relationship with the accused party."

Parole Domestic Violence Specialized Caseload

Domestic violence is a distinctive type of interpersonal violence due to the relationship between the perpetrator and victim, and the complex array of physical, psychological, sexual, stalking, and coercive and controlling behaviors that make up intimate partner violence (CDC, 2018; Spencer et al., 2020). It typically occurs in an ongoing or cyclical way involving both criminal and non-criminal behaviors rather than as a single criminal event, as found in other offense types. Domestic violence affects not only

those who are abused but also any children and other family members, and it is a known risk factor for the intergenerational transmission of violence (Ehrensaft & Langhinrichsen-Rohling, 2022). These features of domestic violence result in it being treated as a distinct subcategory of offending within the research literature.

According to the most recent CDC National Intimate Partner Violence Survey (2018), 36% of women and 34% of men reported experiencing domestic violence in their lifetime. Additionally, 1 in 5 women and 1 in 7 men reported experiencing *severe* physical domestic violence. National crime statistics indicate that of the 4,970 female victims of murder and nonnegligent manslaughter in the US in 2021, 34% were killed by an intimate partner (BJS, 2022). Colorado statistics indicate that of the 366 homicides in 2021, 91 (25%) involved domestic violence incidents and 58 (16%) involved victims of domestic violence being killed (Colorado Domestic Violence Fatality Review Board, 2022). In 2023, domestic violence accounted for 11% of all homicides in Colorado (Colorado Domestic Violence Fatality Review Board, 2024).

Many different efforts to reduce domestic violence and minimize harm have been implemented both in Colorado and elsewhere. Some of these approaches have evidence of benefit but that is not universal (Travers et al., 2021; Washington State Institute for Public Policy, 2013). Approaches include specialized judicial programs (e.g., domestic violence courts), judicial monitoring, specialized domestic violence community supervision, and global positioning system monitoring. Additional interventions include offender domestic violence treatment, adjunct substance abuse and mental health treatment, and victim services (Washington State Institute for Public Policy, 2013). Support for specialized domestic violence caseloads comes from a probation study that found it led to less domestic violence recidivism, greater offender accountability, and increased contact by services with victims (Klein et al., 2005). Another study indicated that the use of evidence-based techniques when supervising domestic violence offenders is greater when officers are specifically trained, manage a specialized caseload, and believe in the effectiveness of their supervision (Spencer et al., 2020).

A recent pilot project launched by the Division on Parole explored the utility, feasibility, and potential benefits of a Domestic Violence Specific Specialized Caseload. The pilot was intended to run for six months beginning in May of 2023, with the main purpose being the design and implementation of a domestic violence specialized caseload made up of parolees who have mittimus with domestic violence (proven) associated convictions. These identified parolees were enrolled into enhanced community supervision modeled similarly to that of community supervision for sex offenders in an effort to have a positive effect on supervision outcomes and community safety. The Colorado Springs Parole Office was identified as the pilot sight involving two specialized supervision unit officers with mixed caseloads. The pilot was overseen and supported by a group of parole and DVOMB-specific staff.

The duties of the Community Parole Officers (CPO) in the pilot included:

- Reviewing assigned cases before release regarding the parole agreement and requirements related to Domestic Violence Offender Treatment, Intensive Supervision Program (ISP), and any no-contact restrictions with the identified victim.
- Ensuring the Treatment Coordination Case Manager (TCCM) was aware of the designation and treatment needs for intake.
- Sending collateral information to the assigned DVOMB Approved Provider before intake.

- Ensuring the assigned Pre-Parole Investigation was appropriate.
- Ensuring treatment intake was scheduled and completed regarding the regular and ISP directives if applicable, and any specified domestic violence directives.
- Following contact standards of 1x per week until treatment intake was completed, and the supervision level was determined per the DVRNA. Home visits were to be completed in the first 30 days of release and all other contact standards were to be determined by the supervision level.
- Addressing violations utilizing the community sanction model, and if violations were significant in nature or posed a risk to public safety, the case was to be staffed through the chain of command and documented as soon as possible.
- Staff each case as a member of the MTT one time per month with applicable chronological entries.

A substantial body of research has examined the correlates of domestic violence in a broad range of offender and community-based samples. Research has shown that domestic violence offenders typically have multiple criminogenic risk factors and more significant overall criminogenic risks than non-domestic violence offenders (Hilton & Radatz, 2018; Stewart & Powers, 2014). In a recent large study, these criminogenic risk factors predicted future domestic violence (Hilton & Radatz, 2018). Similarly, a recent meta-analysis found that treatment programs that follow the risk-need-responsivity principles and target criminogenic factors were more effective at reducing domestic violence recidivism than programs that did not (Travers et al., 2021). In addition to the high-risk high-need that typifies many domestic violence offenders, a significant challenge for supervision and treatment provision is that when recidivism occurs, it often happens shortly after the start of a community sentence. This is before the positive effects of treatment or supervision can be realized (Garner et al., 2021; Klein et al., 2005). Other research with domestic violence offenders has found being in full-time employment following program completion significantly and substantially reduced recidivism, further indicating the benefit of a combined focus on treatment and community stability (Grace et al., 2022).

A large number of domestic violence cases are being sentenced to the Department of Corrections. In FY 2023, 10.1% (n=1,153) of the court cases sentenced to the Colorado Department of Corrections also included a finding by a judicial officer of domestic violence. These cases may parole in the future, indicating that specialized caseloads managing domestic violence cases will be critical for public safety. Further complications with domestic violence offenders that support a specialized supervision model include that some domestic violence offenders have significant psychopathic personality traits, and that domestic violence is a major contributor to homicide fatalities (Juodis et al., 2014).

Recommendation

Support and encourage the Division of Parole in the creation and continued development of policies and procedures for domestic violence specialized caseloads and requirements for parolees to include attendance at and completion of domestic violence offender treatment.

Safety Protections for DVOMB Approved Providers

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. DVOMB Approved Providers undergo extensive training and supervision to become mental health practitioners and specialize in the evaluation, assessment, and treatment of domestic violence offenders. The context for this specialization intersects with various areas of behavioral health, trauma-focused treatments, problematic substance use, and other related areas of illegal behavior and criminality.

In the course of delivering services, DVOMB Approved Providers must navigate their own personal safety and wellbeing. In a recent survey conducted by the DVOMB, a majority of Approved Providers endorsed feeling safe working with clients (93%) and reported that their interactions at work were safe (90%). While these results are encouraging, repeated anecdotes of circumstances endangering the health, safety, and welfare have emerged in recent years that highlight that while relatively infrequent, serious threats do occur. Details of these anecdotes are censored from this report to ensure the safeguarding and confidentiality of Approved Providers who have shared this sensitive information. In general, these examples include Approved Providers being:

- Physically threatened, harassed, and intimidated
- Verbally abused
- Stalked and monitored, even after the domestic violence offender has discharged from treatment

A degree of aggressive and hostile behaviors toward Approved Providers is not uncharacteristic of those who have engaged in domestic violence offenses. Research notes that this complex population often presents with more criminogenic needs than that of the general offending population, meaning they are at higher risk for repeat aggressive and violent behavior (Hilton & Radatz, 2018). Approved Providers afflicted by these serious threats have reported that the criminal legal system did not hold clients who engaged in these behaviors accountable. In one case, a client was discharged and transferred to another program after making threats to the Approved Provider. This client was not admitted to the new program due to further similar behavior. However, the presiding court subsequently dismissed their domestic violence case despite reports to law enforcement of this threatening behavior.

Recruiting and retaining the most talented mental health professionals is undermined when these behaviors go unsanctioned and without consequences. The Office of Domestic Violence and Sex Offender Management (ODVSOM) has been actively developing a formal recruitment strategy, which Section 3 of this report describes. Enhanced statutory protections would assist in the ongoing efforts to recruit and retain Approved Providers. In summary, Approved Providers deserve the same protections afforded to other specialized professions and occupations at risk for aggression, hostility, and violence. Safeguards can help deter problematic behavior and serve as an important indication as to the value we place on these professionals who help enhance the safety of individuals, families, and communities across Colorado.

Recommendation

Extend the special class of protected victims to that of DVOMB Approved Providers and Treatment Victim Advocates similar to that of other protections identified in § 18-3-203, C.R.S., for peace officers, fire fighters, emergency medical providers, etc. Individuals who commit or threaten acts of violence, harassment, or stalking against DVOMB Approved Providers or Treatment Victim Advocates should warrant higher criminal or civil penalties. This does not preclude a defendant from filing a formal complaint or complaints against an Approved Provider with the DVOMB or any other regulatory organization.

Section 3: Milestones and Achievements

Overview of FY 2024 Accomplishments

The Domestic Violence Offender Management Board (DVOMB) achieved several notable milestones during FY 2024, underscoring its commitment to advancing the field of domestic violence offender treatment and supervision in Colorado. Per legislative mandates introduced in HB 22-1210, the DVOMB made significant progress in meeting compliance review requirements while continuing to implement the data collection plan. A core focus on best practices, cultural responsivity, and provider recruitment led to initiatives such as continuing to partner with Orange Circle to develop recruitment and retention strategies. Additionally, the Board conducted its first Approved Provider Survey to assess treatment service fees and the overall health of the field. It expanded community engagement through traveling board meetings and roundtable discussions and initiated a project to revise the Domestic Violence Risk and Needs Assessment (DVRNA) to reflect recent study findings and advancements in risk assessment.

The DVOMB effectively managed its operations through six active committees, which reviewed 191 provider applications and significantly revised sections of the *Standards and Guidelines* to align with statutory changes, empirically-based best practices, and culturally responsive approaches. The Board successfully delivered 40 training events attended by over 1,700 participants statewide, including a co-hosted four-day conference engaging a wide range of stakeholders, from treatment providers to law enforcement officers. The DVOMB also continued its monthly technical assistance hours, offering essential support to providers to stay informed and navigate the standards. As of July 2024, the Board maintained a list of 171 active DVOMB Approved Providers throughout Colorado, with 132 approved with the added specialization to work with female clients and 59 with LGBTQIA+ clients.

Update on Implementation of Reauthorization Requirements

The latest Sunset Review by the Colorado Department of Regulatory Agencies occurred in 2022 and resulted in the reauthorization of the DVOMB for five years until 2027. As per HB 22-1210, the reauthorization bill required the DVOMB 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 1, 2023.
- Perform compliance reviews on at least 10% of DVOMB Approved Providers every two years beginning no later than July 1, 2023, and
- On or before January 31, 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.

The DVOMB has made substantial progress in implementing each of these requirements. In particular:

- The DVOMB approved a data collection plan in 2022, and this was implemented on schedule, becoming operational on January 1, 2023. The DVOMB provides two platforms for data submission to Approved Providers. The first option is the Provider Data Management System (PDMS), established and maintained by the Colorado Department of Public Safety and free for providers. The second option is through ReliaTrax, a privately operated health record company that is subscribed to by many Approved Providers.[12] The data collection system provided the source for the aggregate summary of client services and characteristics presented in Section One.

- The policies and practices for Standards Compliance Reviews (SCRs) conducted by the DVOMB are outlined in the *Standards and Guidelines Appendix D Administrative Policies (VI)(B)*. The DVOMB Application Review Committee (ARC) administers SCRs, which can be conducted voluntarily, randomly, or for cause. Once an SCR and any resulting Compliance Action Plan are completed, an Approved Provider selected at random is exempt from another random SCR for six years. However, they may still be subject to a For Cause SCR at any time. The DVOMB ARC is on target to complete the required SCRs on at least 10% of Approved Providers every two years. Based on the number of Approved Providers listed at the end of FY2022-2023, the DVOMB needed to administer at least 15 Standards Compliance Reviews by June 30th, 2025. As of the date of publication, 16 SCRs have been initiated, more than the 10% of Approved Providers requirement.

- The 2025 DVOMB Annual Legislative Report is the third year the DVOMB has provided a legislative report to the House and Senate Judiciary Committees. It addresses the criteria stipulated in HB 22-1210 and highlights the DVOMB's work. Prior year reports are accessible through the DVOMB website.

Efforts to Enhance Culturally Responsive Care

The DVOMB continues to prioritize culturally responsive care efforts including:

- DVOMB Diversity, Equity, Inclusion, and Belonging (DEIB) Committee.

- Seeking to recruit members to the DVOMB and its committees from diverse groups within the provider community and its stakeholders.

- Providing training events that target supporting and increasing cultural competency.

- Hosting training on Assessing Risk for Sexual and Domestic Violence: Latest Research Including Cross-Cultural Validity by Dr. Maaike Helmus, Simon Fraser School of Criminology.

[12] The DVOMB partnered with ReliaTrax as many Approved Providers were existing subscription customers, and this allows the convenience of avoiding duplicate data entry. ReliaTrax and the DVOMB have successfully collaborated to integrate the DVOMB data collection requirements.

- Developed an ODVSOM Training Conduct Policy that outlines expectations for training participants and DVOMB Staff procedures for responding to inappropriate or abusive comments regarding any person's identity or culture.

- Guest speakers at monthly DVOMB meetings to honor various cultural heritage months throughout the year (e.g., Asian Heritage Month, African American Heritage Month).

- Additional revisions to the *Standards and Guidelines* to ensure policies respect diverse perspectives and facilitate discussion from all individuals.

These efforts and training opportunities aim to enhance the understanding and capacity of the DVOMB and affiliated stakeholders to address issues of cultural competence and cultural responsivity impacting their work. They also aim to foster a climate of respect, inclusiveness, and belonging for people within the DVOMB community.

Efforts to Recruit New Providers

The ODVSOM began a multiphase project in 2022 to develop a communications plan to attract new providers to the domestic violence and sex offender treatment fields. The ODVSOM partnered with Orange Circle Consulting (Orange Circle), a marketing and research agency. The first phase of the project involved formative research of potential recruits and existing stakeholder groups. Strategies were used to ensure the findings could inform the development of recruitment strategies and resources that would be effective across potential recruits from diverse cultures. This is part of an overall strategy to provide a culturally responsive provider community. The main findings from that research are summarized in the DVOMB 2023 Annual Legislative Report and were communicated to the DVOMB and SOMB at their monthly meetings and to stakeholder groups in attendance.

The project's second phase commenced in FY 2024 once further funding was secured. It involved a continued partnership with Orange Circle to develop specific outreach strategies and materials for provider recruitment. The focus was on testing targeted messaging for specific audiences regarding the work of the ODVSOM, its importance for public safety, and the positive impact it has on individuals who engage in domestic violence and abuse. To gather feedback, three focus groups were assembled with key audiences to assess the messaging and information delivery methods. The insights obtained from these groups were used to design tailored outreach strategies that effectively connect with the people who need information about the ODVSOM.

In the project's final phase in the upcoming fiscal year, Orange Circle will collaborate with current Approved Providers to produce a video showcasing their clinical work and the positive impacts of being an Approved Provider. The final project phase will also involve creating appealing resources that can be used for recruitment drives and integrated into existing slide presentations to promote the ODVSOM. These recruitment tools are intended to be used in partnership with university social work and forensic mental health programs around the state.

Community and Stakeholder Outreach

Traveling Board Meetings

The DVOMB held a traveling board meeting in September 2023 in Grand Junction, Mesa County. Traveling board meetings are designed to help the DVOMB connect with the communities it serves across Colorado. DVOMB staff contact Approved Providers and stakeholders who reside and practice in the counties hosting and surrounding the site for the traveling board meeting to encourage attendance and participation. While regular business is conducted at these meetings, there is also an emphasis on updating attendees about recent DVOMB activities and hearing about local concerns and initiatives. Knowledge gained from these outreach meetings is fed to the relevant DVOMB committees and addressed in the policy and resource work as appropriate. The DVOMB plans for one traveling board meeting per calendar year. Individuals or agencies can request a DVOMB meeting be held in their community through the DVOMB website or by contacting DVOMB staff.

Round Tables

The DVOMB held roundtable discussion meetings in July 2023 on the Southern Ute Reservation, Igancio, in August 2023 in Durango, La Plata, and in December 2023 in Boulder. The purpose of roundtable discussions is to improve collaboration, engagement, and the exchange of feedback between the Board and communities statewide in a safe and constructive manner. The roundtable discussions are open to Approved Providers, stakeholders, and community members to come together to dialogue about challenges, opportunities, and ways to work together to address and prevent domestic violence. The morning session focuses on dialogue and discussion, while the afternoon session offers training and discussion on specialized topics. DVOMB staff contact Approved Providers and stakeholders who reside and practice in the counties hosting and surrounding the site for the roundtable to encourage attendance and participation. Individuals or agencies can request the DVOMB hold a roundtable in their community through the DVOMB website or by contacting DVOMB staff.

Domestic Violence Taskforce Development

Over the past year, the DVOMB Implementation Specialist collaborated with Montrose County to design and establish a Domestic Violence Taskforce. This initiative involved providing a detailed framework outlining the essential components of Domestic Violence Taskforces and offering technical assistance to stakeholders in forming this cross-agency team. The Montrose Domestic Violence Taskforce has now been successfully constituted and has commenced regular meetings.

Inaugural DVOMB Provider Survey

The DVOMB designed and conducted a short survey of Approved Providers in 2024 to understand fair-market prices for domestic violence offender treatment services and gather information about providers' experiences delivering treatment services in Colorado. The survey canvassed service fees, payment collections, referrals and contracts, the MTT approach, and workplace safety and wellbeing. A primary objective of the survey was to assist in understanding the needs of underserved areas of Colorado and potential challenges to recruiting and retaining Approved Providers throughout Colorado. The survey is anticipated to be conducted periodically, with some flexibility in topics and questions to inform policy needs and concerns.

Forty-one independent practitioners and multi-provider agencies responded to the survey, accounting for approximately 55–76% of the Approved Provider community.[13] The response rate indicates that 63% were from urban areas, and 37% were from rural or frontier areas. On average, the providers delivered treatment services across four to five counties. The average length of working in the domestic violence offender treatment field was 13 years (range 1 to 37 years). As shown in **Table 3**, half of the providers who responded indicated monthly caseloads contained 1–49 clients, while half had 50 or greater. The survey appears to have sampled from a broad range of the Approved Provider community.

Table 3: Monthly Caseloads, DVOMB Provider Survey FY 2024 (Count 41).

Monthly Caseload	Count[a]	Percent
1-24	9	22%
25-49	12	29%
50-74	8	20%
75-99	5	12%
100+	7	17%

a. Survey responses from multi-provider agencies were considered a single data point for this analysis.

Cost of Services and Payment Collection

The survey inquired about domestic violence offender treatment services fees, as shown in **Table 4**. The survey found fees for in-person and teletherapy group sessions are similar within the same judicial district, with an average price of $39.71 for in-person group treatment sessions and $39.97 for teletherapy group treatment sessions. However, the average fee for group treatment sessions ranges significantly across judicial districts from $30.00 at the low end to $85.00 at the high end.[14] The survey also found the fee for individual in-person and teletherapy sessions is similar within the same judicial district, although less uniformly than with group treatment sessions. The average fee for in-person individual treatment sessions is $82.97, while the average for individual teletherapy sessions is $82.81. At the low end, it is $30.00, and at the high end $128.33. The average fee for adjunct therapies varies across judicial districts, while the fee for evaluations is reasonably similar across judicial districts with a few exceptions.[15] The survey indicated that the fees charged do not vary by specific offender population (i.e., female clients, LGBTQ+ clients) or the client spoken language.

[13] The survey collected agency size using range options (e.g., 1 provider only, 2-5 providers, 6-10 providers etc.). The responses indicated the survey data reflected from 94 to 130 Approved Providers. The percentages were calculated using the number of approved active providers for FY 23-24, as shown in Table 7.

[14] In particular, three judicial districts have group treatment sessions with an average cost above $50 per session.

[15] The cost of evaluations for most judicial districts falls near the average of $213.11, with one district being markedly lower and three notably higher.

Table 4: Average Domestic Violence Offender Treatment Services Fees by Judicial District, DVOMB Provider Survey FY 2024 (Count 41).

Judicial District	In Person Group Treatment	Teletherapy Group Treatment Session	In Person Treatment Session	Teletherapy Individual Treatment Session	Other Adjunct Treatment Session	DV Offender Evaluation
1st	$41.33	$41.33	$93.33	$94.00	$54.64	$210.62
2nd	$42.35	$42.50	$95.36	$92.67	$52.50	$204.12
3rd*	$35.00	$35.00	$35.00	$35.00	$65.00	$75.00
4th	$46.43	$46.43	$112.50	$112.50	$65.00	$295.83
5th	$37.50	$39.38	$86.67	$83.12	$63.12	$187.50
6th	$37.50	$37.50	$100.00	$100.00*	$27.50	$237.50
7th	$41.67	$42.50	$78.33	$83.75	$58.33	$296.25
8th*	$35.00	$35.00	$60.00	$60.00	$30.00	$156.67
9th	$41.25	$42.00	$77.50	$82.00	$91.25	$237.00
10th	$51.67	$51.67	$128.33	$128.33	$95.00	$401.67
11th	$38.75	$40.00	$97.50	$98.00	$75.00	$251.00
12th	$60.00	$60.00	$110.00	$110.00	$75.00	$425.00
13th*	$85.00	$85.00	$122.50	$122.50	$85.00	$487.50
14th	NA	NA	NA	NA	NA	NA
15th*	$30.00	$29.00	$30.00	$30.00	$68.00	$150.00
16th*	$30.00	$29.00	$30.00	$30.00	$68.00	$150.00
17th	$41.79	$42.00	$84.29	$81.07	$56.79	$210.00
18th	$41.94	$42.11	$92.00	$89.71	$56.18	$194.72
19th	$46.43	$47.50	$82.50	$85.71	$82.50	$263.33
20th	$44.55	$44.58	$95.91	$91.82	$62.27	$237.69
21st*	$30.00	$37.50	$75.00	$87.50	$45.00	$255.00
22nd	$37.50	$37.50	$100.00	$100.00*	$27.50	$237.50
Overall Average	**$39.71**	**$39.97**	**$82.97**	**$82.81**	**$56.10**	**$213.11**
Range	**$30-$85**	**$29-$85**	**$30-$185**	**$30-$185**	**$20-$250**	**$65-$775**

*Denotes only one responding provider/agency from that Judicial District.
NA denotes "Not Available" due to the lack of a responding provider/agency from that Judicial District.

Almost all providers surveyed (93%) indicated that clients self-pay for domestic violence offender treatment services. A large proportion (78%) also reported that vouchers issued by the supervising agency supplement payment. Over two-thirds of providers (68%) reported experiencing difficulties collecting payments for services from clients. The survey collected comments on this issue, indicating various circumstances contributed to non-payment and provider financial stress. Themes included:

- **Clients accrue a balance with the promise of payment but end contact without paying.** Clients drop out of contact due to having debt, being discharged due to non-payment, or are discharged when they complete treatment before payment can be realized.
- **Clients do not have the resources to pay for their treatment.** Clients have insufficient funds due to poverty, unemployment, increases in the cost of living, losing access to Medicaid to offset the cost of other treatment services, and less availability of vouchers from supervising agents to supplement the cost.
- **Some clients do not prioritize their domestic violence offender treatment.** Clients have the funds but spend it on other things, lose access to vouchers due to issues maintaining sobriety, or do not show up for appointments.
- **Providers feel pressured to keep offering treatment services despite payment issues.** Supervising agents encourage continuing with clients as they believe payment will be forthcoming or can be resolved, or the court re-instates the client with the same or a new provider after discharge for non-payment.
- **Providers are experiencing an increase in the cost of service delivery.** The cost of service delivery has increased due to inflation, and this is challenging to recoup due to client payment difficulties and fixed-term contracts with supervising agencies.

Provider Workplace Safety and Wellbeing

The survey included questions to gauge Approved Providers' sense of workplace safety and wellbeing. It did this by assessing their level of agreement with a variety of statements that described both positive and negative experiences and perceptions. **Table 5** shows the percentage of those who agreed the statement was true for them. As shown, most providers reported feeling safe in their workplace, with about a third indicating feeling rundown or negatively impacted by their work.

Table 5: Percentage of Approved Providers Who Endorsed Statements Reflecting Workplace Safety and Wellbeing, DVOMB Provider Survey FY 2024 (Count 41).

Statement	Percent Agree
Interactions at work feel safe and respectful	90%
I feel run down and drained of physical or emotional energy	34%
I am hopeful for the future	83%
The demands in my work negatively impact my home and/or family life	29%
Overall, I feel safe when working with domestic violence clients	93%
I feel like I am able to really show compassion to a client	100%
I have seen positive changes in my clients	100%
I have been recognized/appreciated for good work	73%

The survey also inquired about the relationship between using teletherapy modality and a sense of workplace safety. Just over half of the respondents (51%) indicated using teletherapy had led to a greater sense of workplace safety. In contrast, 39% said it had not had an impact and 10% did not use teletherapy. The survey collected comments on this issue. The themes evident were:

- **Teletherapy offers greater physical and emotional safety before, during, and after the group session.** It helps mitigate the impact of negative interactions with clients if they become angry, hostile, or disruptive. It reduces the opportunity to be approached or confronted outside of group sessions by clients or their surrogates. It increases the provider's privacy and lessens the chance of stalking.

- **Teletherapy is a less emotionally challenging environment for clients.** Clients have fewer emotional outbursts and can remove themselves more easily from the setting, or the provider can remove them. Online attendance also lessens potential problems if a client attends under the influence of alcohol or drugs and decreases association with clients with active gang affiliations.

- **Teletherapy offers other general health and safety benefits.** Providers do not have to drive long distances to meet with clients, especially in winter. Providers who are immune-compromised can limit their exposure and continue to work.

- **Teletherapy is a useful option but not necessary or suitable for all clients.** Of note, several comments indicated the provider liked having the option of teletherapy to manage these concerns when present but did not provide all treatment services via teletherapy. Some comments also referred to teletherapy as inappropriate for many clients or being revoked as an option when a client could not engage satisfactorily through teletherapy.

Additional Insights: Post-COVID Challenges

A substantial proportion of providers believe there is a shortage of DVOMB Approved Providers (51%), while over a third (39%) reported challenges for the field returning to in-person services. Issues included staff turnover among supervising agents, leading to increased case management workload without proper compensation. Others commented that several agencies do not appear to have transitioned back to in-person treatment and, as a consequence, are treating higher-risk clients using teletherapy who are unsuitable for teletherapy.[16]

Another key theme emerging was that since the pandemic, the clients being referred for domestic violence offender treatment programs are more complex, at higher risk of recidivism with more significant treatment needs. Issues included:

- Clients are less willing to attend sessions, less engaged, and more resistant to treatment.
- Clients present a higher risk and density of treatment issues, adversely impacting their readiness and suitability for treatment without additional interventions.
- Pressure to accept referral into treatment despite their low likelihood of successfully completing treatment within the 12-month supervision sentence.
- Sentences and court orders occasionally undermine the treatment process and requirements of the *Standards and Guidelines*. Issues included clients having sentences waved after unsuccessful discharge, clients being transferred among multiple agencies instead of revoked and resentenced following repeated unsuccessful attempts at treatment, teletherapy being sought for clients who are not suitable for this modality, and lack of understanding about roles and procedures within the MTT.

Domestic Violence Risk Need Assessment Revision (DVRNA-R)

The Colorado DVRNA is a structured risk assessment used to evaluate and place domestic violence offenders into differential treatment levels in Colorado. The DVOMB was developed and implemented in 2010. It comprises 14 risk domains (e.g., prior domestic violence-related incidents), each with a range of risk items indicative of that risk domain. 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.

In FY 2023, the DVRNA was evaluated to examine its predictive validity. The validation study contained a sample of 787 individuals referred for domestic violence offender evaluation who had a completed DVRNA and who gave permission to access their criminal recidivism records in future research. The study found the DVRNA placement level separated the domestic violence offenders into valid risk groups that differed by domestic violence and general recidivism rates. The DVRNA total score showed

[16] In part, this was raised as a concern as providers were accepting transfer clients who were either administratively or unsuccessfully discharged from teletherapy treatment who were subsequently required to do in-person treatment at the new agency.

it had small to moderate predictive accuracy. A description of the study and the main findings were included in the DVOMB 2024 Annual Legislative Report.

In FY 2024, a project was initiated to develop further the psychometric strengths and clinical utility of the DVRNA using the validation study findings, advances in the field of risk-need assessment, and considering updates to the *Standards and Guidelines*. The DVOMB staff, with the assistance of the DVOMB Standards Revision Committee, developed a revised version of the DVRNA, currently named the DVRNA-R. The DVRNA-R will be piloted and reviewed further before replacing the DVRNA. The pilot study began in FY 2024 and will continue in FY 2025. The pilot study involves Approved Providers who volunteered to participate and includes some judicial partners.

Applications for Placement on DVOMB Approved Provider List

During FY 2024, the DVOMB ARC reviewed and approved 190 applications. **Table 6** displays the three major types of applications managed by the ARC. The Committee managed 21 initial applications, which refers to applications for Associate Level Candidacy to start practicing as an Approved Provider under supervision while obtaining the necessary training to progress to the Associate Level. The Committee managed 33 status upgrade applications, which refer to applications that move up the listing status (e.g., from Associate to Full Level) or add a new specialization (e.g., specific offender populations). The Committee managed 137 renewal applications, where a DVOMB Approved Provider applied to continue at the current listing status.

Six of the status upgrade applications were for Special Offender Population approval to work with female clients and one was to work with LGBTQIA+ clients.

Many of the applications involve a collaborative process whereby the ARC communicates with the applicant to ensure that the required information is provided and that any ambiguity or concerns regarding the application are adequately addressed. This collaboration is a factor in the high approval rate.

Table 6: DVOMB Count of Applications FY 2024.

Application Type	Number Submitted	Number Approved	Number Pending[a]
App 1 - Initial Listing as Candidate[b]	21	21	0
App 2 - Listing or Level Upgrade	33	32	1
App 3 - Renewal	137	137	0
Total	191	190	1

a. Pending refers to applications with missing information or pending staff/ARC review.
b. This was formally listed as Entry Level or Provisional Status.

Current Availability of DVOMB Approved Providers

As of the end of FY 2024, the DVOMB had 171 active and 21 not currently practicing treatment providers in Colorado. **Table 7** presents the breakdown according to the listing levels in the *Standards and Guidelines*. In FY 2024, the Associate Level Candidate was introduced to replace the former Trainee Status category. In FY 2023, the Clinical Supervisor Apprentice category was introduced to provide a clearer pathway to becoming a Clinical Supervisor. A Clinical Supervisor Apprentice or Clinical Supervisor listing indicates that the provider is also a Full Operating level provider. Although the total number of active Approved Providers has increased between FY 2023 and FY 2024, this reflects the addition of the Associate Level Candidate to the reporting.

The *Standards and Guidelines* include two listings for specific offending populations to identify those providers approved to work with female and LGBTQIA+ individuals. Of the active Approved Providers, 132 were approved to work with female clients and 59 were approved to work with LGBTQIA+ clients. Approved Providers also have the option of identifying their spoken languages. Of all the active providers, 39 (22.8%) identified themselves as capable of providing services in Spanish. Other languages covered by providers were Portuguese, Vietnamese, and German.

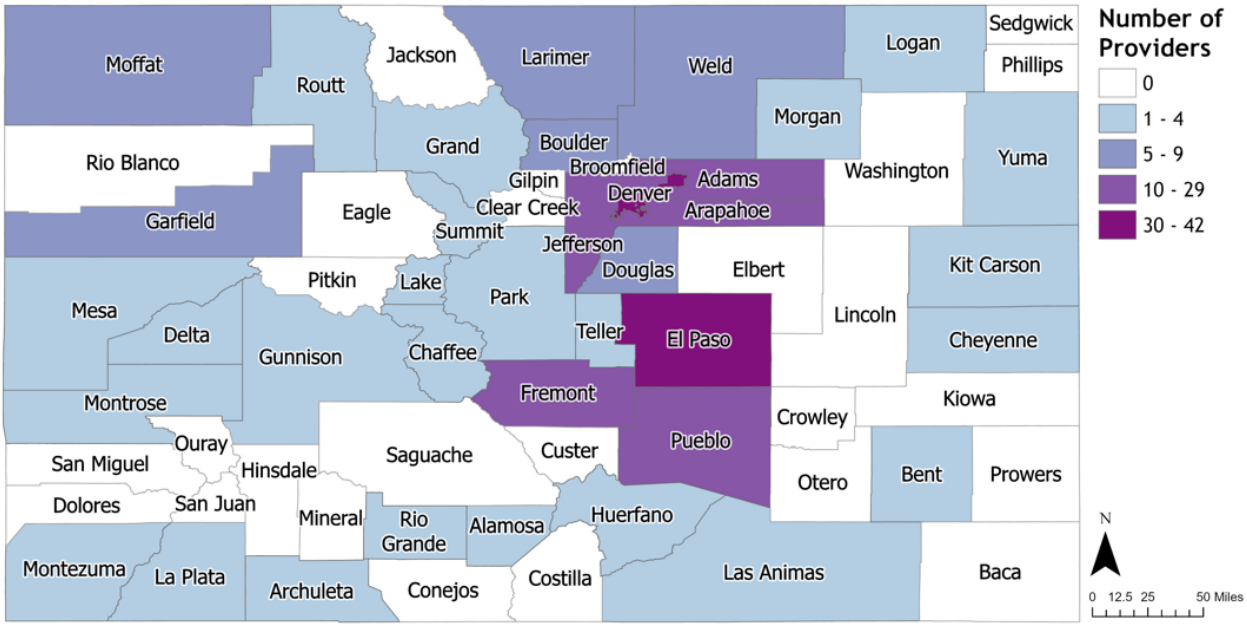
Table 7: Number of Approved Providers in Colorado FY 2024.

Level	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Associate Level Candidate[a]	-	-	-	-	-	24
Associate	26	40	35	36	39	40
Full Operating	81	88	94	90	82	71
Clinical Supervisor Apprentice[b]	-	-	-	-	2	6
Clinical Supervisor	45	35	37	31	29	30
Subtotal	156	166	168	159	153	171
Not Currently Practicing[c]	23	21	23	16	32	21
Grand Total	179	187	191	175	185	192

a. Associate Level Candidate was introduced in FY 2024 to replace the Trainee Status category.
b. Clinical Supervisor Apprentice was a new category introduced in FY 2023.
c. Not Currently Practicing allows Provider to retain their listing status when not providing direct services.

Figure 9 shows the number of Approved Providers by county. On average, Approved Providers operated in two different counties. In total, the DVOMB has Approved Providers located in all 22 judicial districts in the state.

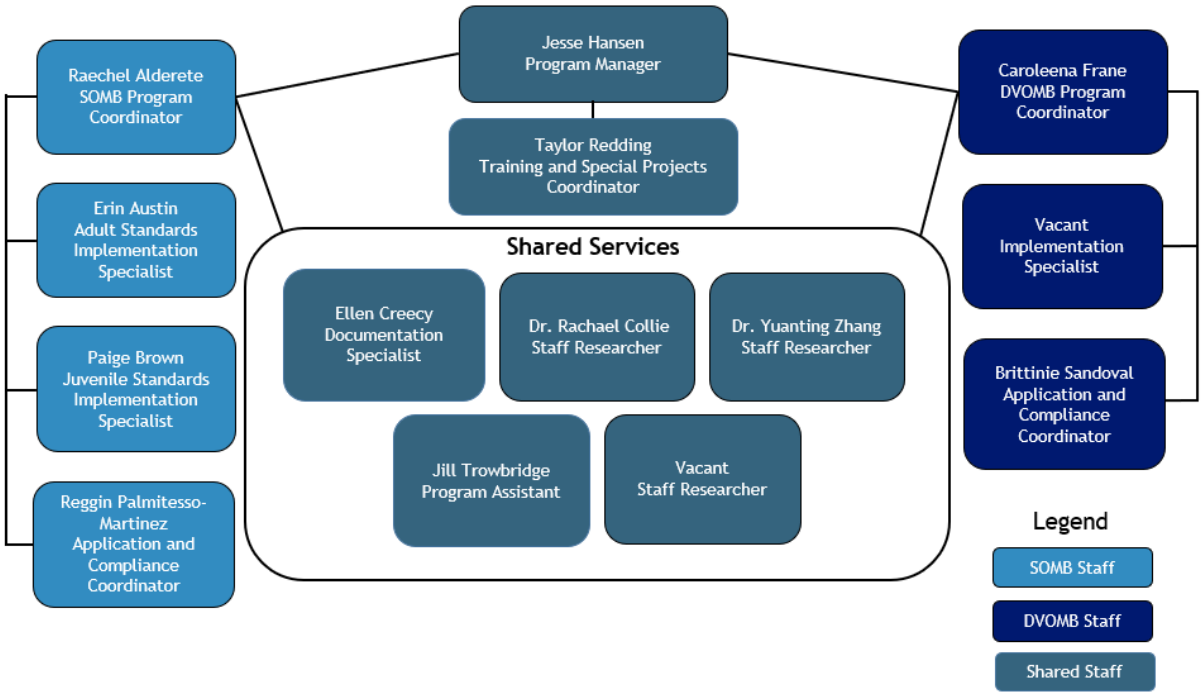
Figure 9: Number of DVOMB Approved Providers by County in Colorado FY 2024. For data table, see Appendix A.



ODVSOM Shared Services Model

The ODVSOM provides the program staff that supports the DVOMB and the Sex Offender Management Board (SOMB). Initially, the staff for the DVOMB and SOMB were separate. However, in 2016, the staff was merged into one office because both entities had similar structures, guiding principles, and mandates. This merger helped minimize overlapping duties and streamlined technical and policy responsibilities while continuing to support each Board's distinct legal status. In 2022, the support staff organizational model was refined to integrate staff roles to be more responsive to the increase in Approved Providers, the complexity of the respective *Standards and Guidelines*, and additional expectations following sunset reviews. **Figure 10** shows the current staff configuration. The new organizational structure was fully implemented in 2023.

Figure 10: The ODVSOM Shared Services Model and Organizational Chart FY 2024. For the data table, see Appendix A.



The Shared Services Model centralizes the administrative, planning, and research staff that support the DVOMB and SOMB. Additional specialized positions for each Board designate primary staff to provide direct support and leadership. These include the DVOMB and SOMB program coordinators for strategy and operations, DVOMB and SOMB implementation specialists for the respective *Standards and Guidelines*, and DVOMB and SOMB Application and Compliance Coordinators. A training and special projects coordinator works across the DVOMB and SOMB, and the Program Manager is responsible for staff support for the Boards.

Several impacts of the revised organizational structure are apparent, including:

- Enhanced outreach and support for the provider community and other stakeholders in rural and frontier areas.
- Increased training for the provider community and stakeholders across the state.
- Expansion and refinement of the implementation specialist role through staff undertaking training and certification in implementation.
- Streamlined provider application and renewal process to benefit the provider community and reduce the administrative workload of the ARC.
- Increased research to support policy and standards revisions.

Policy Updates

The DVOMB primarily works through committees to discuss and review policy and implementation issues. Appointed members, program staff, and other stakeholders attend the committees. All committee meetings are also open to the public and conducted online or in a hybrid format to maximize accessibility. The committees regularly update the DVOMB about their work, bringing forth proposals to address policy and practice issues at monthly Board meetings. Some proposals involve recommendations for revisions to the *Standards and Guidelines*, whereas others can include suggestions for white papers, policy briefs, resource documents, or training to support best practices. All of these committees consider advancements in the domestic violence offender treatment and management field when conducting their work. When recommending changes to the *Standards and Guidelines*, the committees support their proposals with research and best practices and suggest methods for educating practitioners and the public to implement effective offender management strategies.

During FY 2024, the DVOMB staffed six active committees and workgroups to fulfill its statutorily mandated duties. All committees were open to all stakeholders and members of the public. The committees were:

- Executive Committee
- Application Review Committee
- Diversity, Equity, Inclusion, and Belonging Committee
- Standards Revisions Committee
- Victim Advocacy Committee
- Training Committee (in collaboration with the Sex Offender Management Board)

Significant policy work conducted in FY 2024 included:

- Revision to Section 1.0 Domestic Violence Offender Management Board to clarify the purview of the Board pursuant to § 16-11.8-103(4)(a)(II) C.R.S.
- Initiated work on a resource paper that offers guidance to DVOMB Approved Providers when addressing orders of child-parent reunification, pursuant to HB 23-1178, involving domestic violence offenders under the purview of the DVOMB *Standards and Guidelines*.
- Revision to Section 5.0 Standards of Practice for Treatment Revision to clarify the purpose and purview of domestic violence offender treatment.
- Revision to Section 5.01 Principles of Effective Interventions for Domestic Violence Offenders to more clearly emphasize the requirement to prioritize victim safety, ensure culturally responsive care, emphasize individualized treatment, recognize the role of environmental and cultural influences, and ensure the fidelity of practice.

- Revision to Section 9.0 Provider Qualifications to align with changes by the Department of Regulatory Agencies concerning Certified Addiction Technician and to introduce an Associate Level Candidacy to replace Trainee listing for new providers to enter the field.

- Revision to Section 5.08 Treatment Competencies to reflect advances in empirical research concerning dynamic risk factors and treatment effectiveness and create greater coherence between evaluation, treatment planning, and progress monitoring.

- Revision to Section 5.03(VI) Treatment Modality Language regarding the client's preferred language and the use of Interpretation Services.

- Revision to Section 7.0 Victim Advocacy to align with statutory changes concerning confidentiality, clarify required and recommended training, and reflect current best practices in victim advocacy with survivors of domestic violence.

- Policy briefs including Important Considerations for Sentencing Domestic Violence Offenders (April 23, 2024) and Validation of the DVRNA and the Requirement for a Second Risk Assessment Related to Domestic Violence (May 10, 2024).

A summary of the main work of each committee in FY 2024 is provided in **Appendix B**.

Ongoing Implementation

The implementation process involves sharing information from the DVOMB with Approved Providers and members of the MTTs to ensure understanding and compliance with the *Standards and Guidelines*. Key elements of implementation involve communication, training, and support. Communication strategies and activities include emails to share information, a quarterly newsletter, and announcements at meetings and events. The DVOMB website is kept up-to-date and houses the *Standards and Guidelines*, along with other resources and access to training. Training events include core training workshops on the *Standards and Guidelines*, Offender Evaluation and Treatment, and the DVRNA, as well as lunch and learns on practice issues every two months. A series of advanced training seminars and workshops are also offered throughout the year by experts on various topics, as well as the ODVSOM Annual Conference. Support strategies and activities include bimonthly technical assistance hours and staff availability. The DVOMB continually works on its implementation processes and support activities.

Training

In FY 2024, the DVOMB provided 40 trainings and the ODVSOM Annual Conference to over 1700 attendees across Colorado. Over 500 stakeholders attended the ODVSOM Annual Conference in person.[17] The training events covered a range of topics related to the treatment and supervision of individuals convicted of domestic violence offenses, such as:

- DV100 - DVOMB and Standards Overview

[17] 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.

- DV101 – Domestic Violence Risk and Needs Assessment Training
- DV102 – DV Offender Evaluation Training
- DV103 – DV Offender Treatment Training
- DV200 - DVOMB Community Roundtable Discussions
- Probation Officer Training
- Evidence-Based Supervision of Intimate Partner Violence Perpetrators
- DVRNA and Multidisciplinary Treatment Team for Probation Officers
- Aurora Municipal DVOMB Training
- Clinical Supervision
- Racial and Generational Trauma: Evidence-Based Somatic Interventions for BIPOC Clients
- Living Life Vicariously Through Clients: Reducing Vicarious Trauma and Burnout Among Professionals Working with Traumatized Populations
- Intimate Partner Violence Strangulation
- DV Case Conceptualization
- Uncovering a Hidden Addiction: Problem Gambling as a Cause and Effect of Interpersonal Violence
- Parental Alienation as a Form of Power and Control
- Assessing Risk for Sexual and Domestic Violence Recidivism: Latest Research, including Cross-Cultural Validity
- Risk Assessment Training
- DVRNA-R 2-day Training
- Why Every Piece of the Puzzle Matters: Coordinated Community Response for Intimate Partner Violence
- DV Interstate Compact
- What Happens to Domestic Violence Victims When Sentencing is Over? Treatment Victim Advocates, Ongoing Safety, Resources, and Victim Input in Offender Treatment
- Overview of DVOMB and Victim Advocacy Post-Conviction

Summary

The following highlights some of the many additional achievements of the DVOMB in FY 2024:

- Managed six DVOMB committees
- Managed 198 applications for placement, continued placement, or specialization on the DVOMB Approved Provider List during FY 2024.
- As of July 2024, there were 171 active and 21 not currently practicing DVOMB Approved Providers in Colorado. Of those treatment providers, 132 were approved to work with female clients and 59 were approved to work with LGBTQIA+ clients.
- Conducted 40 training events for over 1,700 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 advocates, law enforcement, court personnel, and other stakeholders.
- On-track with implementation of the requirements included in HB 22-1210 concerning reauthorization of the DVOMB, notably the required number of Standards Compliance Reviews and implementation of the PDMS.
- Continue to prioritize and integrate culturally responsive care initiatives.
- Partnered with Orange Circle to move to phase two of the recruitment and retention communication and marketing strategy that involves development of targeted communication strategies and development of resource materials.
- Conducted Inaugural Approved Provider Survey to understand and track the fees for domestic violence offender treatment services and assess the health of the domestic violence offender treatment field.
- Continued community and stakeholder outreach with a yearly traveling board meeting and various community roundtable discussions.
- Initiated a project to revise the DVRNA to build upon findings from the FY 2023 validation study, advances in the field of risk-need assessment, and to align with updates to the *Standards and Guidelines*.
- Made several significant revisions to the *Standards and Guidelines* to incorporate statutory changes, reflect empirically informed advances in best practices, and support culturally sensitive and responsive treatment.
- Supported monthly technical assistance hours. On a monthly basis, DVOMB staff one-hour technical assistance sessions for Approved Providers. This allows staff to update providers on recent changes to the *Standards and Guidelines* and allows providers to have questions answered.

Section 4: Future Goals and Directions

The mission of the DVOMB, as written in its enabling statute, is to have a 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 assessing and treating domestic violence offenders have been a "work in progress." Thus, periodic revisions to improve the *Standards and Guidelines* remain a key strategic priority for the DVOMB as new research and evidence-based practices emerge and are adopted. 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. Implementing the data collection mandate allows the DVOMB to examine evaluation and treatment services in Colorado and forge locally informed policies and practices.

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Appendices

Appendix A. Data Tables

Figure 1: Treatment Modality Combinations 1/1/23–1/23/24 (Count 1,448)

Treatment Modality Combinations (Count 1,448)	Percent of Clients
In Person Only	45.8%
Teletherapy Only	45.0%
Mixed Modalities	9.3%

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Figure 2: Distribution of Treatment Modalities by Treatment Level Placed 1/1/23–1/23/24

Treatment Level A (Count 45)

Treatment Modality Combination	Number of Clients	Percent (%)
In Person Only	8	18%
Teletherapy Only	35	78%
Mixed Modalities	2	4%

Treatment Level B (Count 417)

Treatment Modality Combination	Number of Clients	Percent (%)
In Person Only	149	36%
Teletherapy Only	234	56%
Mixed Modalities	34	8%

Treatment Level C (Count 984)

Treatment Modality Combination	Number of Clients	Percent (%)
In Person Only	504	51%
Teletherapy Only	382	39%
Mixed Modalities	98	10%

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Figure 3: Discharge Outcome by Treatment Modalities and Risk Level 1/1/23–1/23/24

Treatment Level A (Count 45)

Discharge Outcome	In Person Only # of Clients	In Person Only Percent (%)	Teletherapy # of Clients	Teletherapy Percent (%)	Mixed Modalities # of Clients	Mixed Modalities Percent (%)
Completed	6	75.0%	29	82.9%	2	100.0%
Unsuccessful	0	NA	5	14.3%	0	NA
Administrative	2	25.0%	1	2.9%	0	NA

Treatment Level B (Count 416)

Discharge Outcome	In Person Only # of Clients	In Person Only Percent (%)	Teletherapy # of Clients	Teletherapy Percent (%)	Mixed Modalities # of Clients	Mixed Modalities Percent (%)
Completed	100	67.6%	190	81.2%	33	97.1%
Unsuccessful	31	20.9%	38	16.2%	1	2.9%
Administrative	17	11.5%	6	2.6%	0	NA

Treatment Level C (Count 984)

Discharge Outcome	In Person Only # of Clients	In Person Only Percent (%)	Teletherapy # of Clients	Teletherapy Percent (%)	Mixed Modalities # of Clients	Mixed Modalities Percent (%)
Completed	222	44.0%	218	57.1%	65	66.3%
Unsuccessful	235	46.6%	149	39.0%	28	28.6%
Administrative	47	9.3%	15	3.9%	5	5.1%

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Figure 4: Median Treatment Length by Modality Type, Treatment Level, and Discharge Type 1/1/23–1/23/24.

Treatment Level A (Count 45)

Discharge Outcome	In Person Only Median Treatment Length (Months)	Teletherapy Median Treatment Length (Months)	Mixed Modalities Median Treatment Length (Months)
Completed	4.1	NA (no clients)	8.7
Unsuccessful	NA (no clients)	NA (no clients)	4.1
Administrative	NA (no clients)	NA (no clients)	NA (no clients)

Treatment Level B (Count 413)

Discharge Outcome	In Person Only Median Treatment Length (Months)	Teletherapy Median Treatment Length (Months)	Mixed Modalities Median Treatment Length (Months)
Completed	8.0	8.7	8.8
Unsuccessful	3.2	NA (no clients)	4.1
Administrative	3.2	NA (no clients)	2.7

Treatment Level C (Count 984)

Discharge Outcome	In Person Only Median Treatment Length (Months)	Teletherapy Median Treatment Length (Months)	Mixed Modalities Median Treatment Length (Months)
Completed	9.5	8.9	9.0
Unsuccessful	3.0	6.5	2.5
Administrative	3.7	3.3	3.2

Overall Median Treatment Lengths

Modality Combination	Median Treatment Length (Months)
In Person Only	6.2
Mixed Modalities	8.3
Teletherapy Only	7.8

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Table 1: Client Demographics FY 2024.

Gender (Count 1,994)	Number of Clients	Percent (of known)
Male	1,606	81%
Female	385	19%
Non-Binary	*	*
Transgender Male	*	*

*Data suppressed to maintain client confidentiality according to DVOMB policy to routinely suppress data when a cell has less than 5 cases.

Age (Count 1,994)	Mean	Range
Age (At Time Of Offense)	34	18 to 89

Sexual Orientation (n = 1,994)	Number of Clients	Percent (of known)
Heterosexual	1,921	96%
Bisexual	24	1.2%
Gay	24	1.2%
Lesbian	15	0.8%
Self-identify	5	0.3%
Pansexual	*	*
Asexual	*	*
Questioning	*	*

*Data suppressed to maintain client confidentiality according to DVOMB policy to routinely suppress data when a cell has less than 5 cases.

Race/Ethnicity (Count 1,994)	Number of Clients	Percent (of known)
White	1,010	53%
Hispanic	614	32%
Black or African American	165	8.7%
Native American or American Indian	43	2.3%
Latino	32	1.7%
Asian or Pacific Islander	22	1.2%
Not listed here	16	0.8%
Missing	92	NA

Hispanic Origin (Count 1,994)	Number of Clients	Percent (of known)
Not Hispanic Origin	1,066	63%
Mexican	485	29%
Not Listed Here	110	6.5%
Puerto Rican	16	0.9%
Latino	11	0.7%
Missing	306	NA

Primary Language (Count 1,994)	Number of Clients	Percent (of known)
English	1,555	92%
Spanish	130	7.7%
Mandarin	*	*
Not Listed Here	*	*
Missing	306	NA

*Data suppressed to maintain client confidentiality according to DVOMB policy to routinely suppress data when a cell has less than 5 cases.

Highest Education (At Time of Offense) (Count 1,994)	Number of Clients	Percent (of known)
High school degree or equivalent (e.g., GED)	940	56%
Less than high school degree	394	23%
Bachelor degree	113	6.7%
Associate degree	101	6.0%
Vocational schooling	91	5.4%
Graduate degree	31	1.8%
Some college but no degree	14	0.8%
Doctoral degree	*	*
Missing	306	NA

*Data suppressed to maintain client confidentiality according to DVOMB policy to routinely suppress data when a cell has less than 5 cases.

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Figure 5: Number of Domestic Violence Treatment Clients by Referral Source FY 2024 (Count 1,994).*

Referral Source*	Number of Clients	Percent (%)
Probation	1,709	86%
Private Probation	142	7%
Community Corrections	60	3%
Court	44	2%
Parole	42	2%
Diversion	27	1%
Other	3	<1%
County DHS/DYS	2	<1%
Private Attorneys	1	<1%

*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 6: Distribution of Treatment Levels Placed for Colorado DV Treatment Clients FY 2024 (Count 1,987).

Treatment Level	Number of Clients (n)	Percent (%)
Level A	42	2%
Level B	511	26%
Level C	1,434	72%

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Figure 7: Discharge Outcomes by Treatment Level Placed for Colorado DV Treatment Clients FY 2024 (Count 1,987)

Treatment Level A (Count 42)

Discharge Outcome	**Number of Clients**	**Percent (%)**
Completed Discharge	35	83%
Unsuccessful Discharge	3	7%
Administrative	4	10%

Treatment Level B (Count 511)

Discharge Outcome	Number of Clients	Percent (%)
Completed Discharge	386	76%
Unsuccessful Discharge	102	20%
Administrative	23	5%

Treatment Level C (Count 1,434)

Discharge Outcome		Number of Clients	Percent (%)
Completed Discharge		713	50%
Unsuccessful Discharge		636	44%
Administrative		85	6%

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Figure 8: Treatment Length for Colorado DV Treatment Clients by Treatment Level Placed FY 2024 (Count 1,987)

Treatment Level A (Count 42)

Discharge Type	Median Length of Treatment (Months)
Completed	7.4
Unsuccessful	4.1
Administrative	2.1

Treatment Level B (Count 511)

Discharge Type	Median Length of Treatment (Months)
Completed	8.7
Unsuccessful	2.8
Administrative	2.7

Treatment Level C (Count 1,434)

Discharge Type	Median Length of Treatment (Months)
Completed	9.4
Unsuccessful	3.0
Administrative	2.9

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Figure 9. Number of DVOMB Approved Providers by County FY 2024

County Name	Number of Providers
Adams County	23
Alamosa County	2
Arapahoe County	29
Archuleta County	2
Baca County	0
Bent County	1
Boulder County	8
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	42
Dolores County	0
Douglas County	8
Eagle County	0
El Paso County	34
Elbert County	0
Fremont County	18
Garfield County	5
Gilpin County	0
Grand County	1
Gunnison County	1
Hinsdale County	0
Huerfano County	2
Jackson County	0
Jefferson County	27
Kiowa County	0
Kit Carson County	1
La Plata County	3
Lake County	1
Larimer County	7
Las Animas County	1
Lincoln County	0
Logan County	1

County Name	Number of Providers
Mesa County	3
Mineral County	0
Moffat County	6
Montezuma County	1
Montrose County	3
Morgan County	2
Otero County	0
Ouray County	0
Park County	1
Phillips County	0
Pitkin County	0
Prowers County	0
Pueblo County	18
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	4
Teller County	1
Washington County	0
Weld County	9
Yuma County	1
Unknown County	6

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Figure 10. ODVSOM Shared Services Model and Organizational Chart 2024.

Position	Staff Member
ODVSOM Program Director	Jesse Hansen
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	Ellen Creecy
ODVSOM Staff Researcher	Dr. Rachael Collie
ODVSOM Staff Researcher	Dr. Yuanting Zhang
ODVSOM Staff Researcher (0.3)	Vacant
ODVSOM Program Assistant	Jill Trowbridge
DVOMB Program Coordinator	Caroleena Frane
DVOMB Implementation Specialist	Vacant
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 FY 2024

Executive Committee

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

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.

Major Accomplishments: The Executive Committee met regularly for an hour monthly throughout FY 2024 to debrief DVOMB meetings and plan for the next meeting. Planning included identifying relevant updates from other DVOMB committees and organizing guest presentations on salient issues and commemorative months. The Executive Committee attended to pending revisions to policies, policy briefs, Board vacancies, and provided oversight to attendance at DVOMB meetings.

Future Goals: The Executive Committee will continue to maintain the mission of the DVOMB.

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 (SCRs), and other administrative actions. The ARC consists of Board members appointed by the ARC Chair and confirmed through consensus by the Board.

Major Accomplishments: The ARC met monthly throughout FY 2024 for between three to four 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 renewal approval, as well as applications for associate level candidacy, and status upgrades.

- The Committee managed, assessed, and resolved thirty complaints, many of which were already open at the beginning of FY 2024 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 FY 2024 and had resolved 25 complaints by the end of FY 2024. The majority of

the complaints were dismissed by DORA or deemed unfounded by the ARC. A small number resulted in for cause SCRs.

- The Committee managed multiple SCRs and three compliance action plans.

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

Standards Revisions Committee

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

The Standards Revision Committee (SRC) comprises Approved Providers, Supervising Officers, and Treatment Victim Advocates (TVAs). Its primary goals are to enhance victim safety and develop effective treatment strategies for offenders by recommending updates to the *Standards and Guidelines* as directed by the DVOMB. The Committee aims to incorporate recent research on treatment practices and to engage all stakeholders in the revision process. Additionally, it seeks to improve coordination and consistency among domestic violence treatment providers and Multidisciplinary Treatment Teams (MTTs). Finally, the SRC intends to make recommendations to the DVOMB regarding the treatment and evaluation of domestic violence offenders.

Main Accomplishments: The SRC has met monthly online for two hours throughout FY 2024. Major highlights include:

- Continued the revision of the offender treatment competencies, including final revision, public comment, and presentation to the Board for ratification.
- Developed scoring criteria and examples for the revised pilot of the DVNRA.
- Proposed revisions to the treatment modalities, including placing more emphasis on motivational enhancement and treatment responsiveness interventions and strategies.
- Proposing revisions to the offender treatment contract.

Future Goals: The SRC intends to continue working on revisions to the treatment-related *Standards and Guidelines* within Section 5.0 and responding 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

The DEIB Committee welcomes Approved Providers, Supervising Officers, Treatment Victim Advocates, and other stakeholders from all heritages and backgrounds to create a diverse group that brings various viewpoints and life experiences. Its goals include making recommendations on DVOMB policies and

procedures to support culturally responsive care through enhancing cultural competency, addressing biases, and considering social justice issues affecting the DVOMB *Standards and Guidelines*. Additionally, the Committee aims to identify relevant training content areas for future DVOMB meetings and Approved Providers.

Major Accomplishments: The DEIB Committee met monthly online for two hours throughout FY 2024. The work of the Committee addressed EDI issues across workforce development, clinical practice, and multidisciplinary team practices. Highlights include:

- Review of language interpretation options and best practices to ensure these were incorporated into the revision to interpretation services in the *Standards and Guidelines*.
- Recommended cultural awareness and competency training options.
- Review of Training and Conduct Policy to address culturally inappropriate comments and actions.
- Discussed and suggested activities for consideration for the ODVSOM Annual Conference
- Developed a philosophy statement requirement for DVOMB provider applications.
- Discussed options to integrate DEIB committee member expertise into other DVOMB committees.

Future Goals: The DEIB Committee intends to continue supporting cultural awareness and responsiveness within other committees and the provider community. 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

The Victim Advocacy Committee (VAC) brings together Treatment Victim Advocates (TVAs), Victim Services Officers, Approved Providers, Supervising Officers, and other stakeholders to prioritize victim safety and confidentiality. It aims to empower victims of domestic violence to make informed choices about their interaction with TVAs, foster collaboration and support for TVAs, and recommend improvements to DVOMB standards and policies regarding victim impact, safety, and best practices.

Major Accomplishments: The VAC met monthly online for two hours during FY 2024. Highlights included:

- Working on revisions to Section 7.0 of the *Standards and Guidelines*: Victim Advocacy, which involved proposing revisions to TVA qualifications and clarifying confidentiality issues. The proposed revisions were released for public comment and reviewed and ratified by the Board.
- Reviewed proposed revisions to Section 3.0 of the *Standards and Guidelines*: Guiding Principles.

- Held a joint meeting with the SOMB Victim Advocacy Committee to discussed shared issues and create opportunities for learning and collaboration.

- Held presentations on cultural awareness and sensitivity concerning Latino victims of domestic violence and on justice, equity, diversity and inclusion for victims-survivors.

- Discussed implications for domestic violence offender treatment due to loss of victim services funding.

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 monitoring and problem-solving the impacts of the loss of victim services funding.

ODVSOM Training Committee (Conjoint with SOMB)

Committee Chair: Sonja Hickson
Committee Co-Chair: Xaviera Turner

Purpose: The Training Committee consists of Approved Providers, Supervising Officers, TVAs, Victim Representatives, and other stakeholders who work together to achieve several goals. Their main responsibilities include identifying relevant training topics and objectives, planning large-scale training events, including the annual conference, and assessing training needs related to domestic violence and sex offender management. Additionally, the committee focuses on developing trainers in collaboration with other agencies, providing support based on available resources, and recommending training needs and best practices to program staff.

Main Accomplishments: The Training Committee met monthly online for two hours during FY 2024. The Committee debriefed the 2023 ODVSOM Annual Conference and prepared for the 2024 conference. The Committee developed a conference and training code of conduct to appropriately set expectations and address culturally inappropriate comments or actions during training events. The committee continued to work on developing a broad range of training initiatives that both provide content-specific knowledge and create opportunities for the development of a practice community. The committee continued emphasizing culturally responsive care initiatives within ODVSOM educational activities.

Future Goals: The Training Committee will continue to plan training events and find opportunities for conjoint DVOMB and SOMB activities. The Committee is also working on creating opportunities for greater victim voices to be included at the ODVSOM conference and continuing to support cultural awareness within training.

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