DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD

ANNUAL LEGISLATIVE REPORT

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

DVOMB

A Report of Findings Pursuant to **§ 16-11.8-103(5.5)(a), C.R.S.**

January 2026

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DVOMB 2026 Annual Legislative Report

Accessibility Accommodations

The Division of Criminal Justice and the **Office of Domestic Violence and Sex Offender Management (ODVSOM)** is committed to the full inclusion of all individuals, and we are continually making changes to improve accessibility and usability of our services. As part of this commitment, the **ODVSOM** is prepared to offer reasonable accommodations for those who have difficulty engaging with our content. As an example, documents can be produced in an alternative file format upon request. To request this and other accommodations, or to discuss your needs further, please contact **ODVSOM** by phone at **303-239-4526** or emailing the **DVOMB staff**.

Acknowledgements

The DVOMB gratefully acknowledges the contribution of Dr. Agatha Chronos, who conducted the literature review on couples counseling under the supervision of Dr. Rachael Collie during an internship with the Office of Domestic Violence and Sex Offender Management (ODVSOM). This literature review was subsequently edited and served as the foundation for the couples counseling material presented in Section 1 of this report.

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Executive Summary

Pursuant to **§ 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 **§ 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

To assess emerging practices and their alignment with Colorado's regulated domestic violence treatment system, the **DVOMB** conducted targeted literature reviews on **Restorative Justice (RJ)** and **Couples Counseling**—two approaches that remain widely debated in the domestic violence field. These reviews were not intended to replace existing standards but to determine whether any components of these models warrant consideration as **supplemental**, highly regulated practices under limited circumstances.

The **DVOMB** anchored its analysis in the **Principles of Effective Intervention (including the central Risk-Need-Responsivity principles; RNR)**, the consensus framework endorsed across correctional and behavioral intervention fields. Colorado's domestic violence treatment model already fully adheres to the RNR principles and is recognized nationally as a rigorous, accountability-driven system with strong victim-centered protections.

Restorative Justice (RJ): Findings and Implications

Interest in **RJ** has grown nationwide, but research specific to **domestic violence** remains sparse and methodologically inconsistent.

- **The evidence base is limited and mixed.** A handful of small studies report promising reductions in recidivism and high survivor satisfaction, while others show no significant benefit compared to traditional prosecution or domestic violence treatment programs.
- **Findings are not generalizable to Colorado's court-mandated population.** Existing studies focus on voluntary, screened, lower-risk participants, with weak documentation of facilitator training, fidelity, safety protocols, and long-term outcomes.

- **Victim safety remains a central concern.** Domestic violence dynamics involve coercive control and power imbalances that heighten risks when victims and offenders are brought into direct or indirect contact.

- **Comparable lessons from Colorado's SOMB.** The Sex Offender Management Board's (SOMB's) "victim clarification" process demonstrates how restorative elements (e.g., accountability letters, optional survivor engagement) can be safely integrated within a highly structured, survivor-centered system.

Policy Implication: RJ should not replace or operate parallel to the **DVOMB *Standards and Guidelines***. **Narrowly defined, supplemental RJ-informed practices** may be explored under careful safeguards—lower-risk eligibility, survivor opt-in, specialized facilitator training, and embedded evaluation—and would require standards revisions, planning, and coordination.

Couples Counseling: Findings and Implications

As with RJ, **Couples Counseling** remains highly contested due to safety concerns, power imbalances, and the risk of reframing abuse as a mutual relationship problem. **DVOMB *Standards and Guidelines* currently prohibit conjoint sessions** during domestic violence offender treatment; however, this does not preclude couples work after completion of domestic violence treatment.

- **Evidence shows limited and context-specific benefits.** The strongest support comes from military populations participating in highly structured programs like Strength at Home—Couples (SAH-C).

- **Generalizability is poor.** Research often excludes high-risk cases and relies heavily on self-report, small samples, and short follow-ups.

- **Safety risks remain significant.** Potential for coercion, retaliation, or minimization of abuse underscores the need for extreme caution.

- **Unexplored potential for adjunctive use.** No studies have tested couples counseling as a follow-on or adjunct to offender treatment—an area relevant for couples who remain together or for offenders entering new relationships post-treatment.

Policy Implication: Consistent with current evidence and statutory mandates, the **DVOMB's prohibition on couples counseling** during offender treatment remains sound. Limited exploration of adjunct or follow-on conjoint work during maintenance phases of treatment could be considered only after robust standards review, survivor opt-in, specialized provider training, and clear gatekeeping criteria.

Overarching Conclusions

Across both reviews, a consistent pattern emerges:

- Promising outcomes appear primarily in **narrow**, **lower-risk**, **highly controlled** contexts.

- Evidence is **insufficient to justify any significant changes** to the **DVOMB's current treatment framework**.

- Innovations, if pursued, must occur through **tightly regulated**, **pilot-based**, **supplemental** approaches grounded in victim safety, offender accountability, and RNR principles.

The **DVOMB** remains committed to continuous improvement within Colorado's regulated treatment system. To ensure a cautious, evidence-driven approach, future efforts will first explore the feasibility, safety, and statutory compliance required for developing limited supplemental practice pilots, followed by the integration of PDMS data collection into any resultant evaluation efforts.

DVOMB Data Analysis

Data Collection Overview

- The **DVOMB** completed its **second full year of data collection** (Year 2: July 1, 2024, to June 30, 2025), which resulted in a final dataset of **4,260 client records**.
- Data submission significantly increased, notably from 1,994 records in Year 1, and records were submitted from **all 23 Judicial Districts** (up from 21 in Year 1).
- The data collection system uses a combined approach of provider entry through either the internal **Provider Data Management System (PDMS)** (6.6% of records) or the private **ReliaTrax** system (93.4% of records).
- Client consent to share personal identifying information for future recidivism tracking increased to **83%** (up from 78% in Year 1).

Background and Client Characteristics

- Most clients were **male (79%)**.
- The average age was **34 years** (ranging from 18 to 84 years).
- Client race/ethnicity was reported as: **White (50%)**, **Hispanic (33%)**, and **Black or African American (11%)**.
- **English** was the primary language for **87%** of clients, followed by **Spanish (12%)**.
- The most common relationship status the offender had with the victim of the index offense was **separated (30%)**.
- **Probation** was the referral source for the vast majority of clients, accounting for **88%** (3,755 clients) of referrals.

Assessment and Evaluation Variables

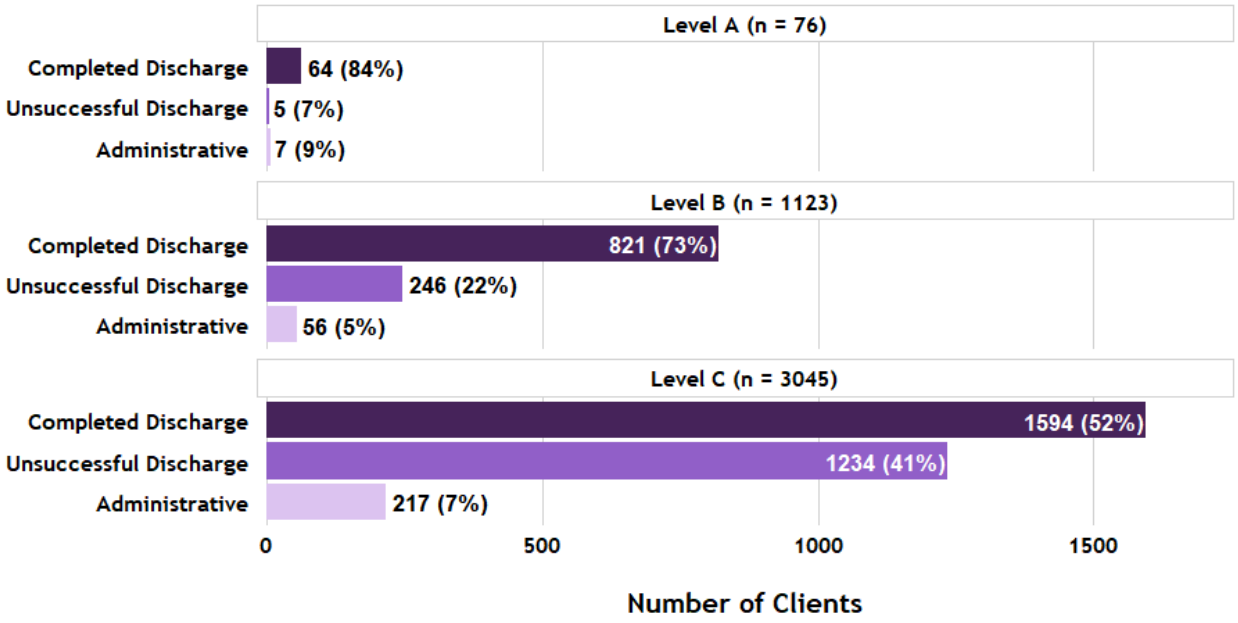
- **92%** of clients had an evaluation completed by an Approved Provider within 30 days of referral.
- Law Enforcement Summary Reports were the most common type of document used during evaluation (**96%**).

- The majority of clients were placed in the two highest-intensity treatment levels: **Level C (High Intensity) at 72%** and **Level B (Moderate Intensity) at 26%. Level A (Low Intensity)** clients represented only **2%**.
- Second contacts/adjunct treatments were most frequently referred for **mental health treatment (40%)** and **substance abuse treatment (36%)**.

Treatment Outcomes and Duration

- Among all recorded discharge types—completed, unsuccessful, and administrative—**58%** were **completed discharges**.
- The rate of successful completion corresponded to the risk level: **Level A (84%)**, **Level B (73%)**, and **Level C (52%)**.

Discharge Outcomes by Treatment Level, FY 2025 (Count 4,244). Data Table Appendix A.



- The median duration of treatment for all clients was **6.7 months**.
- The median treatment length for clients with a **Completed Discharge** was **8.4 months**. Level C clients who completed treatment had the longest median duration at **8.7 months**.
- For clients with an **Unsuccessful Discharge**, the median duration was significantly shorter, with Level B and Level C clients averaging only **2.7 months**, indicating that clients at higher risk disengage—or never meaningfully engage—in treatment within the first **90 days**.
- The most common reasons for unsuccessful discharge included **Unsuccessful - Administrative Other (69%)** and **Excessive Absences (12%)**.

Treatment Absences and Modalities

- **Over half of clients (61%)** missed **four or more** treatment sessions; average seven absences.
- **15%** of clients did not miss any treatment sessions.
- **59% of clients received treatment exclusively through in-person sessions** (up from 45% in Year 1), while **31% received treatment exclusively through teletherapy.**
- **Fewer absences was correlated with the use of the in-person only modality** compared to mixed or teletherapy only.

Summary and Conclusions

Year 2 marks a **major step forward** in the PDMS initiative, with **4,260 client records submitted statewide** and strong provider participation in evidence-based data collection. The data show clear alignment with the **RNR model**: assessments are completed promptly, treatment dosage matches assessed risk-needs, and providers implement tailored responsivity adjustments to support client engagement.

Across the system, three themes stand out:

- The client population remains **highly diverse**, reinforcing the importance of responsivity-informed approaches.
- **Early attrition among higher-risk clients** remains a critical challenge, with unsuccessful discharges occurring at a **median of only 2.7 months**. This pattern highlights the **need for deeper inquiry** into the drivers of early dropout and the factors that support successful completion among higher-risk clients.
- Greater use of **in-person service delivery** is associated with **improved attendance**, underscoring the importance of treatment modality decisions.

Overall, Year 2 data confirm that the *Standards and Guidelines* provide a strong, evidence-based foundation for domestic violence intervention in Colorado. The PDMS now offers a **robust quantitative and qualitative dataset** that the DVOMB will use to guide targeted improvements, support ongoing evaluation, and establish baseline measures for future policy and practice enhancements.

Section 2: Relevant Policy Issues and Recommendations

Section 2 of the DVOMB annual report presents the Board's analysis of significant policy issues, as mandated by HB 22-1210. This year, the DVOMB addressed two significant emerging topics: (1) the increasing use of **pre-trial diversion** for domestic violence cases, and (2) the **Colorado Supreme Court's ruling in *People v. Crawford***, which clarifies important legal standards governing stalking.

Domestic Violence Cases in Diversion Programs and the Statutory Purview of the DVOMB

The **DVOMB** conducted this policy analysis in response to the expanding use of **pre-trial diversion programs for domestic violence cases** across Colorado. While diversion offers a path to avoid conviction, the DVOMB holds **no statutory authority or regulatory oversight** over these non-conviction cases. This has the potential to create a difference between conventional post-conviction public safety standards and local diversion programs.

The primary difference centers on client risk and program suitability, resulting in poor alignment to the RNR principles. Diversion programs are **generally considered most appropriate for low-risk individuals (Level A)**. Yet **DVOMB** data consistently shows that the vast majority of domestic violence offenders referred for treatment are **moderate (Level B) or high-risk (Level C)**. In fact, the low-risk offender (Level A) represents only a small percentage of those referred for treatment under the purview of the DVOMB (approximately 2% in the current fiscal year reporting period), severely limiting the number of appropriate diversion candidates.

- **Under-Treatment and Supervision Gaps:** The **DVOMB's** treatment model is **competency-based**, requiring a median duration of eight-to-nine months to complete successfully. Diversion agreements often mandate short, fixed timelines (e.g., six months), which are typically insufficient to address the deep-seated issues or **co-occurring needs** (Second Contacts) like substance abuse or mental health that are common in this population. Cases therefore risk being **under-supervised and under-treated**.

- **Weakened Accountability:** Placement in diversion may inadvertently send a message of leniency, leading offenders to **minimize the impact** of their abuse and resist accountability, which can hinder long-term behavioral change.

- **Systemic Information Gaps:** The current data reporting systems prevent effective long-term evaluation and future risk management for three reasons: (i) there is **no mandatory data reporting** for diversion clients, (ii) diversion lacks required **Multidisciplinary Treatment Team (MTT) oversight**, and (iii) the common practice of **sealing diversion records** can later obscure a client's prior history leading to inaccurate risk assessment if reoffending occurs.

DVOMB Policy Recommendations

To safeguard victims and uphold accountability, the **DVOMB strongly urges the implementation of safeguards for all domestic violence diversion cases**. These recommendations are designed to support District Attorneys and Approved Providers by aligning diversion with evidence-based principles:

1. **Standardized Risk Assessment:** Promote the use of a validated domestic violence risk assessment tool (such as the new **CASCADE tool—Colorado Assessment Scale for Coercion and Abuse Desistance**—once implemented) for all diversion participants to ensure appropriate clinical matching.

2. **Formal Accountability:** Establish a clear structure for immediate notification to prosecutors and the **MTT** if an offender violates treatment or supervision requirements.

3. **Systemic Information Sharing:** Require the sharing of evaluation results and treatment progress among all relevant parties.

In addition, the following recommendations were provided specifically for Approved Providers, and for Prosecutors and District Attorneys:

Recommendations For Approved Providers
1. Consider the **DVOMB *Standards and Guidelines* as a best practice guideline** and apply them based on their professional judgement and discretion for adults placed on diversion.
2. Carefully review any **contractual requirements** from a diversion program before accepting clients. If any concerns arise, it is important to clearly outline expectations related to their role and treatment programming.
3. Consider continuing the practice of **submitting data to the DVOMB on diversionary cases** to aid with future research regarding what populations are being referred to diversion programs and how well those populations perform while on diversion.

Recommendations For Prosecutors and District Attorneys
1. Refer to a **DVOMB Approved Provider** to conduct an offender evaluation.
2. Contemplate the appropriateness for diversion after the completion of the offender evaluation, which includes the results of the **DVRNA (transitioning to the CASCADE)**.
3. Ensure case managers have training and understanding of their roles and responsibilities in the **Multi-Disciplinary Treatment Team**.
4. Establish clear **program requirements and accountability structures** that allow for recourse that can bring forward charges if the diversion client begins engaging in risk-related behavior, violates any treatment or supervision requirements, or drops out of the treatment program.
5. Consider diversion agreements for a period of **12 months.**
6. **Contemplate the impact of sealed diversionary cases**, which may impact the accuracy of risk assessments if those prior records are not accessible to the Approved Provider conducting an evaluation. Although there is a benefit to incentivizing systems that can divert individuals from continued involvement with the criminal legal system, a consequence of sealing records is that it obscures an individual's prior criminal history leading to inaccurate risk assessment if reoffending occurs.
7. Notify victims of the rationale and basis for offering a diversionary program and the contact information of the Treatment Victim Advocate.

In conclusion, any decision to divert domestic violence cases must be **anchored in valid risk assessment and robust supervision protocols.** Diverting moderate- to high-risk individuals without these mandated structures **deviates from evidence-based standards, potentially compromising intervention effectiveness and jeopardizing public safety.**

Stalking — Colorado Supreme Court Decision People v. Crawford (24SA226)

Stalking is a serious and escalating threat that often occurs as part of domestic violence and **signals an increased risk of intimate partner homicide**, as demonstrated in the recent Colorado case of *People v. Krug* (Case No. 2023CR000581, Broomfield County, Colorado). **National data indicate that stalking is widespread, with millions of Americans reporting lifetime victimization.** This causes substantial emotional distress and fear for safety, with many victims enduring prolonged stalking even after obtaining protection orders. The recent Colorado case, which relied heavily on digital forensic evidence, highlights the need for more efficient mechanisms to access electronic communication records promptly pursuant to lawful warrants (Stelloh & Breslauer, 2025). As noted by Rebecca Ivanoff—a former prosecutor and cousin of the victim—"lawmakers should require companies to respond to stalking-related search warrants within 48 hours" (*Dateline*, as cited in Stelloh & Breslauer, 2025, p. 2).

Against this backdrop, the Colorado Supreme Court's decision in ***People v. Crawford***, 24SA226 (May 12, 2025), addressed the constitutional standard for stalking, balancing victim protection with the First Amendment's free expression safeguards. The ruling distinguished between two standards, clarifying the scope of the U.S. Supreme Court's "**true threats**" requirement from ***Counterman v. Colorado*** (2023). The distinction is established as follows:

- **The *Counterman* Requirement (Recklessness *Mens Rea*):** This heightened mental state (proving the defendant consciously disregarded a substantial risk that their words would be perceived as threatening) **applies only to stalking cases based on threatening communications** ("true threats").

- **The *Crawford* Clarification (Conduct-Based Stalking):** The Court held that the *Counterman* recklessness requirement **does not apply to stalking charges based on repeated, non-speech conduct** (e.g., repeated contacts, approaches, or surveillance).

This distinction is crucial, as the Court affirmed that **content-neutral, conduct-based stalking does not invoke First Amendment protections**. The First Amendment is not violated if a jury hears about communication content, so long as the conviction is based solely on the **fact and frequency of the contacts**, not the content itself.

Crawford **preserves the enforceability of Colorado's stalking statute** against repetitive, intrusive conduct, ensuring that most stalking prosecutions can proceed without the heavy burden of proving subjective recklessness for non-threatening communications.

Victim Safety and Domestic Violence Treatment Impact

- The ruling **reinforces the legal tools available to prosecutors** by prioritizing the victim's right to be free from persistent, unwanted attention and emotional damage caused by repeated, unwelcome conduct.

- The decision has a direct impact on **domestic violence offender treatment referrals** by ensuring that stalking cases based on objective, high-risk conduct can be successfully prosecuted and referred to treatment programs focused on **recidivism risk**, preventing potential dismissal under a broader interpretation of *Counterman*.

Section 3: Milestones and Achievements

During FY 2025, the **DVOMB** achieved significant milestones, advancing domestic violence offender treatment and supervision across Colorado. The Board's achievements across its core mandates demonstrated full compliance with reauthorization requirements, advancements in provider oversight, and significant progress in risk assessment and recruitment efforts.

Reauthorization Compliance and Data Infrastructure

The **DVOMB** successfully met all three core requirements established by **House Bill (HB) 22-1210**, which reauthorized the Board until 2027:

- **Data Collection:** The **DVOMB's** comprehensive data collection plan was **fully operational** on schedule (January 1, 2023), completing its second full year. The system uses a combined approach of the internal **Provider Data Management System (PDMS)** and integration with the private system **ReliaTrax**, yielding a substantial amount of client-level data for deeper insights into client factors and treatment outcomes.
- **Compliance Reviews:** The Board **met the statutory requirement** to perform Standards Compliance Reviews (SCRs) on **at least 10% of Approved Providers every two years**. The Application Review Committee (ARC) conducted **20 SCRs** across FY 2024 and FY 2025, covering **11.4% of active providers**.
- **Annual Reporting:** The **DVOMB** is consistently meeting its annual reporting obligation to the Legislature.

CASCADE Pilot Project: Revision of the Domestic Violence Risk Need Assessment (DVRNA)

The DVOMB successfully completed the pilot of the revised Domestic Violence Risk Need Assessment (DVRNA). The revised instrument has been formally rebranded as the **Colorado Assessment Scale for Coercion and Abuse Desistance (CASCADE)** to better reflect its emphasis on **desistance, survivor/partner safety, and improved outcomes**.

The FY 2025 pilot involved collaboration with more than **60 Approved Providers and diverse judicial partners**, resulting in **150 fully completed assessments**. The pilot confirmed the tool's effectiveness in several critical areas:

- **Risk Differentiation:** The CASCADE incorporates an expanded set of dynamic risk factors and separates them from static factors, allowing for a more comprehensive assessment of risk and **more differentiated spread of risk levels** across the client population.
- **Pilot Data:** Only **21%** of individuals scored in the Highest Risk category, while **38%** scored in the Low Risk category, indicating better separation than the previous tool.

- **Treatment Guidance:** The clear distinction between **static factors (12 items)** and **dynamic factors (21 items)**, combined with the expansion of treatment intensity classifications from three to **five levels**, supports better monitoring of client change over time and more targeted treatment planning.

- **Positive Feedback:** Stakeholder feedback was **overwhelmingly positive**, highlighting the separation of static and dynamic factors and the enhanced ability to **capture change over time** as major strengths.

Next Steps: The project has now entered the Refinement and Analysis phase, which includes further psychometric evaluation and revision of supporting materials. Statewide rollout is planned for FY 2027.

Provider Management: Applications, Complaints, and Oversight

The **DVOMB** maintained oversight of its provider network while focusing on pipeline growth and quality assurance.

- **Provider Applications and Pipeline Growth:** The ARC reviewed **67 applications** in FY 2025, with a **98.5% approval rate (66 approved)**. The **Associate Level Candidate** category expanded to **42 providers**, demonstrating strong growth in the provider pipeline. The provider community includes **181 active providers** located across all 23 judicial districts. **Twenty-eight** applicants successfully advanced their practice level or added specializations (e.g., working with female clients (**140 approved**) and LGBT+ clients (**60 approved**).

- **Provider Complaints and Conduct:** The **DVOMB** managed **17 new complaints** in FY 2025, in addition to 7 carried over from FY 2024. Of the prior-year complaints, **one was founded**, leading to the provider's **permanent removal from the Approved Provider List** due to serious violations of the *Standards and Guidelines*.

- **Standards Compliance Reviews (SCRs):** The SCR process resulted in a **Compliance Action Plan (CAP)** for approximately **33% of finalized reviews** in FY 2024 and FY 2025. CAPs provide a structured way for providers to correct identified deficiencies (e.g., MTT consensus and reporting) under the guidance of a Domestic Violence Clinical Supervisor (DVCS).

Individually Responsive Care (IRC) and Workforce Development

The **DVOMB** has prioritized efforts to ensure its work is responsive to the unique needs of diverse clients and communities.

- **IRC Committee Work:** The IRC Committee worked to **infuse an intentional IRC perspective** across all Board activities, advising on policy updates (like teletherapy to connect clients to native language speakers), ensuring **digital accessibility** of materials, and beginning a comprehensive review of standards guiding work with specific populations (female and LGBTQ+ clients).

- **Recruitment Strategy:** The **Office of Domestic Violence and Sex Offender Management (ODVSOM)** launched Phase Three of its multi-year recruitment project in FY 2025, developing and piloting a **provider video, customizable slide deck, and supplemental video** to attract diverse professionals and strengthen the pipeline in collaboration with university programs.

- **Shared Services Model:** The ODVSOM continues to operate under its fully implemented Shared Services Model (merged **DVOMB** and **SOMB** staff), centralizing administrative, planning, and research functions with role-specific staff—enhancing efficiency and providing specialized support.

Policy, Training, and Outreach

The **DVOMB** advanced critical policy revisions and maintained robust engagement with stakeholders.

- **Policy Updates:** Through its six active committees, the **DVOMB** completed **nine significant policy updates** in FY 2024–2025, strengthening requirements for provider qualifications, teletherapy, treatment contracts/confidentiality, Victim Advocates, and language interpretive services.
- **Training and Development:** The **DVOMB** delivered **26 trainings** and hosted the **ODVSOM Annual Conference**, reaching **over 1,100 attendees** and offering foundational courses (DV 100 series) and specialized topics (e.g., lethality assessment, firearm access).
- **Community Outreach:** The Board continued its commitment to engagement by holding its annual **traveling board meeting in Alamosa** (Alamosa County) to connect with local stakeholders and gather regional input.
- **DVRNA Revision Project:** The **DVOMB** successfully completed the FY 2025 pilot of the **DVRNA-R (Domestic Violence Risk and Needs Assessment – Revised)**. The pilot included over 60 Approved Providers and partners, resulting in 187 assessments completed. The revised tool, now rebranded as the **Colorado Assessment Scale for Coercion and Abuse Desistance (CASCADE)**, successfully produced a broader spread of risk levels and separates static and dynamic risk factors to better guide treatment planning and monitor client change over time. Statewide rollout is planned to begin in FY 2027.

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 is 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**.
- Ordered by the court when it **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

Background

As per **§ 16-11.8-103(4)(a)(I), C.R.S.**, the **DVOMB** is mandated to adopt and implement a standardized procedure for the treatment and evaluation of domestic violence offenders. Further, in its annual report, the **DVOMB** must:

- Address best practices for the treatment and management of domestic violence (are per **§ 16-11.8-103(5.5)(d)**), and
- Report the number of individuals who have undergone domestic violence offender treatment in the preceding year and the outcomes of that treatment (as per **§ 16-11.8-103(5.5), C.R.S.**).

This section highlights significant work undertaken by the **DVOMB in FY 2025** to fulfill these mandates. First, it presents findings from the **DVOMB's** literature reviews on **Restorative Justice (RJ)** and **Couples Counseling**, with attention to methodological limitations, survivor safety, and fit with Colorado's regulated treatment model. Second, it provides key client treatment and discharge outcomes from the **DVOMB Provider Data Management System (PDMS)** for the current reporting year (**Year 2**) and outlines next steps for evaluation, including how PDMS will be used to assess any piloted, standards-compliant supplemental practices.

Research-Informed Best Practices in Domestic Violence Offender Treatment

In **FY 2025**, the **DVOMB** initiated focused literature reviews on two contested approaches to the treatment of domestic violence offenders—**Restorative Justice (RJ)** and **Couples Counseling**. These reviews were undertaken both to meet the Board's statutory responsibility to identify and evaluate b**est practices in domestic violence offender treatment** and as part of its broader commitment to maintaining treatment standards grounded in evidence and responsive to evolving research.

Both RJ and couples counseling involve direct victim–offender interaction and therefore deviate from current **DVOMB** *Standards and Guidelines*, which prohibit conjoint sessions during offender domestic violence treatment due to safety concerns, risks of coercion, and the need to maintain offender accountability as the central focus of treatment. More specifically, Colorado statute prohibits defendants convicted of offenses involving unlawful sexual behavior, domestic violence, stalking, or violation of a protection order from participating in RJ (as per **§ 18-1.3-104(1)(b.5)(I), C.R.S)**. Similarly, **Section 5.09** of the **DVOMB *Standards and Guidelines*** specifies that the **offender—not the couple or the relationship—is the treatment client**; therefore, couples counseling is not permitted during domestic violence offender treatment.

The Board undertook these reviews not to propose either model as a replacement for the existing framework, but to examine whether emerging research supports their potential use as **supplemental practices** under carefully defined conditions. To guide this work, the Board draws on established principles of evidence-informed policymaking, including reviews of meta-analyses, systematic and narrative reviews, high-quality individual studies, and consensus guidelines in offender rehabilitation and domestic violence treatment (APA, 2002, 2019; Satterfield et al., 2009; Taft & Campbell, 2024).

Applying these principles requires attention to the quality, consistency, and applicability of available evidence and expert consensus. The most widely accepted approach to offender rehabilitation is the **Principles of Effective Intervention (PEI)**, also known as the **Risk-Need-Responsivity (RNR) model** (Andrews & Bonta, 2010; Bonta & Andrews, 2024). Crucially, the **DVOMB** model is recognized by experts as fully adhering to the PEI, setting it apart as a model for effective, evidence-based treatment (Radatz et al., 2021; Richards et al., 2021). Research consistently shows that programs adhering to the **RNR** principles achieve meaningful reductions in reoffending, whereas outdated or "one-size-fits-all" models demonstrate little effect (Radatz et al., 2021; Travers et al., 2021). Research also shows that program effectiveness is enhanced when strong integrity is maintained, such as through consistent involvement of qualified practitioners (Gannon et al., 2019).

Against this backdrop, the **DVOMB's** reviews of **RJ** and **Couples Counseling** examined whether these approaches demonstrate sufficient empirical support, ethical safeguards, and compatibility with Colorado's regulated treatment model to warrant consideration as supplemental tools. Importantly, both reviews were designed to address not only questions of therapeutic effectiveness but also implications for survivor safety, voluntariness, cultural responsiveness, and statutory alignment. By conducting these analyses, the **DVOMB** seeks to ensure that discussions of innovation remain grounded in evidence, balanced against known risks, and anchored to the Board's core mandate: enhancing **offender accountability** while prioritizing **victim and community safety**.

Restorative Justice (RJ) in Domestic Violence Offender Treatment: Evidence Summary and Policy Implications

RJ has received growing attention as jurisdictions seek alternative or complementary responses to domestic violence. Advocates argue that **RJ** may offer unique benefits by emphasizing **offender accountability**, **victim voice**, and **community engagement** (Barocas et al., 2022, 2024; Cissner et al., 2019). Critics caution that the dynamics of domestic violence—rooted in **coercive control** and **power imbalances**—create significant risks when victims and offenders are brought into contact (Campbell et al., 2024). The Board prepared a white paper in 2020—Public Safety Considerations and Policy Implications with Restorative Justice in Domestic Violence Cases—which, after review of the literature, concluded that **RJ lacked sufficient empirical support and posed substantial safety, ethical, and legal concerns**. This current review revisits the question in light of subsequent research.

Of importance, Colorado's domestic violence offender treatment model already embodies many principles commonly associated with RJ (e.g., accountability, harm recognition). The **DVOMB** *Standards and Guidelines* establish a rehabilitative, community-based framework for post-conviction treatment and supervision of domestic violence offenders that is robustly grounded in **RNR principles**, individualized assessment (e.g., **DVRNA**), and **competency-based treatment goals**. This competency-based approach prevents therapeutic drift and provides a level of rigor often absent in non-mandated community programs that operate without the regulatory oversight and required treatment standards provided by the **DVOMB**.

Treatment may only be delivered by **DVOMB Approved Providers** who must meet comprehensive qualifications related to education, training, professional licensure, and ongoing supervision, thereby guaranteeing a high level of clinical competence and treatment fidelity across the state. Treatment cases are monitored through **Multidisciplinary Treatment Teams (MTTs)**, which include **Supervising Officers** and **Treatment Victim Advocates (TVAs)**. Within this system, direct victim participation is prohibited, but **restorative-aligned strategies**—such as accountability letters and victim-impact role-plays—can be used when appropriate to promote empathy and responsibility while maintaining safety. These features create a foundation against which **RJ-specific models** can be assessed.

Evidence on the Effectiveness of RJ in DV Contexts

While **RJ** has been widely studied in juvenile justice and non-violent crime contexts (e.g., Islam et al., 2023; Nascimento et al., 2023; Sherman et al., 2015), its effectiveness in domestic violence cases remains **understudied and mixed** (Gang et al., 2021). Survey data and descriptive accounts indicate that **RJ-inspired practices** are being implemented in domestic violence intervention settings more often than the evaluation literature reflects (Cissner et al., 2019). Yet few programs have been systematically examined, and high quality outcome evaluations remain rare. Where evaluations have been conducted, they provide useful but limited insights into the potential and challenges of applying RJ in domestic violence contexts:

- **Mills and colleagues** provide the strongest available evidence, though the findings remain limited. In a randomized trial, combining a hybrid Batterer Intervention Program (BIP) with the Circles of Peace restorative process resulted in a 53% reduction in new arrests; however, domestic-violence-specific outcomes were not reported separately (Mills et al., 2019). The comparison BIP—a Duluth-style program delivered over 18 weeks in mixed-gender groups of first-time misdemeanor DV offenders—may not represent a strong benchmark given the limited effectiveness of Duluth-style programs (Cottie et al., 2020; McNeely, 2019; Travers et al., 2021). As a result, any apparent advantages should be interpreted cautiously. An earlier comparison of Circles of Peace to a minimum 26-week BIP found only short-term reductions in non-DV rearrests and no long-term or DV-specific effects (Mills et al., 2013).[1]
- An Australian Capital Territory Phase Three Restorative Justice Scheme found **high survivor satisfaction**, improved perceptions of safety, and lower violent recidivism among participating adult offenders compared to a statistically adjusted comparison group—however, only **one in four referred participants** were deemed suitable for conferencing, the domestic violence vs. family violence sample was extremely small, **follow-up was limited**, and evaluation activities were disrupted by **COVID-19** (Lawler et al., 2025).
- Two U.S. evaluations found **no significant recidivism differences** between victim-offender mediation and BIPs or traditional prosecution (Payne, 2018; Davis, 2009).

A recent **meta-analysis** illustrates both the promise and limitations of the field. Despite a comprehensive search of published databases and gray literature, the authors identified only **four eligible studies**—three on domestic violence (summarized above) and one on juvenile sexual assault.

[1] Domestic violence in these studies included intimate partner violence, family violence, and violence involving roommates or other cohabitants—a broader definition than that used in Colorado law.

Results indicated a **small but statistically significant reduction in recidivism associated with RJ overall**; however, this **effect disappeared** when the analysis was limited to the two higher-quality studies (Kettrey & Reynolds, 2024). Other exploratory approaches, such as surrogate victim panels where survivors unrelated to the offender share their experiences, suggest **potential benefits** in increasing offender empathy and awareness of harm, but **no evaluations** have examined long-term behavior change, program completion, or recidivism (Kerrigan & Mankowski, 2021; Zosky, 2018).

Methodological Limitations

Despite these occasional promising signals, the evidence base is constrained by recurring methodological limitations. Samples are typically **small**, **voluntary**, and skewed toward **lower-risk cases** where facilitators judged dynamics manageable. **High rates of declinations and non-completions** are common but rarely analyzed, raising concerns about selection bias. Program models vary widely—from single-session conferences to extended circles—and are often combined with other interventions, complicating attribution of outcomes. **Fidelity to restorative principles is inconsistently documented**, with limited information on facilitator training or safeguard protocols. Finally, outcome measures rely heavily on official recidivism data, while survivor-defined safety, autonomy, and well-being are seldom captured, and **long-term follow-up is rare**. These constraints mean that even positive findings **cannot be assumed to generalize to court-mandated domestic violence offender populations**, where risk levels, coercive control dynamics, and statutory restrictions differ markedly from voluntary or community-based contexts.

Taken together, this body of research reflects a cautious but inconclusive evidence base. Some studies suggest RJ can enhance accountability, reduce reoffending, and increase survivor satisfaction, yet others show little or no measurable benefit. Stakeholder studies mirror this ambivalence: survivors, facilitators, and community members often describe RJ as meaningful when it fosters acknowledgment, voice, and healing, but they also emphasize that **voluntariness, facilitator skill, cultural responsiveness, and robust protections against re-harm** are rarely guaranteed in practice.

Synthesis, Implications, and Lessons from Related Fields

Taken together, the empirical record underscores both the conceptual alignment of RJ with accountability goals and the persistent gaps in high quality, **DV-specific evidence**. Small-scale evaluations suggest **potential benefits** for offender accountability and survivor experience, but **methodological weaknesses** and **limited generalizability** constrain confidence. The most consistent findings highlight high survivor satisfaction in voluntary settings, though the risks of coercion, minimization, or re-traumatization remain significant.

The Colorado **Sex Offender Management Board (SOMB) "victim clarification" process** offers a comparative insight into embedding restorative elements within a tightly regulated system. Clarification is a **structured, clinician-led procedure** where offenders, after achieving significant treatment milestones, prepare accountability letters and may—with **survivor consent**—participate in a facilitated dialogue. The process incorporates restorative values (acknowledgment, responsibility, survivor agency) while maintaining clear safeguards: **voluntariness, multidisciplinary oversight, survivor support, and clinical gatekeeping**. Research and provider surveys indicate perceived benefits when these safeguards are appropriately applied. While not equivalent to RJ, clarification demonstrates how **accountability-driven practices** can safely integrate restorative components under a statutory framework that prioritizes victim safety.

For Colorado, these lessons suggest that **RJ should not be adopted as a standalone alternative to DVOMB *Standards and Guidelines***. Instead, it may be appropriate to cautiously pilot RJ-informed practices as **supplemental** interventions, provided strict safeguards are maintained. This would include limiting eligibility to lower-risk cases with demonstrated treatment progress, requiring survivor opt-in, ensuring specialized facilitation, and embedding evaluation from the outset. Critically, **offender accountability, victim safety, and community protection must remain the core priorities**.

Key Takeaways: Restorative Justice in DV Offender Treatment

- **Evidence is limited and mixed.** Only a handful of DV-specific RJ studies exist, with small samples, varied models, and methodological weaknesses. Findings range from promising arrest reductions and high survivor satisfaction to no significant effects. In most respects, **enthusiasm for RJ in domestic violence offender treatment contexts currently outpaces the strength of the empirical evidence.**

- **Positive outcomes are not generalizable.** Most evidence comes from voluntary, lower-risk cases, with few survivor-reported outcomes and short follow-up periods. These results cannot be assumed to apply to court-mandated DV populations.

- **Survivor satisfaction is a consistent theme.** Survivors often value RJ for acknowledgment and voice, but concerns about **coercion**, **re-traumatization**, and **cultural fit** highlight the need for strong safeguards.

- **Comparable lessons exist.** Colorado's SOMB "victim clarification" process demonstrates that restorative elements (e.g., accountability letters, survivor-led dialogue) can be safely integrated within a tightly regulated, survivor-centered framework.

- **Policy implications are clear.** RJ should **not** replace Colorado's **DVOMB** *Standards and Guidelines*. Limited, standards-compliant **pilots may be appropriate as supplemental interventions**—but only for carefully selected cases, only with survivor opt-in, and only under careful oversight and evaluation. For this to be feasible, a lead-in period would be required that includes revisions to the *Standards and Guidelines*, specialized provider training, and consideration of whether current legislation permits the safe delivery of such practices.

Couples Counseling in Domestic Violence Offender Treatment: Evidence Summary and Policy Implications

Couples Counseling has periodically been proposed as an intervention for domestic violence, based on the premise that relationship-focused work could reduce conflict and improve outcomes for some couples. Proponents point to emerging evidence from community and military contexts suggesting that **conjoint interventions** may reduce lower-level violence and improve relationship satisfaction under carefully controlled conditions (Doss et al., 2020; Taft et al., 2016a, 2021, 2024). Critics caution, however, that Couples Counseling **risks reframing abuse** as a mutual "relationship problem" rather than a pattern of coercion requiring offender accountability, while also exposing victims to retaliation, coercion, or re-traumatization (Iverson et al., 2016; Schumm et al., 2018).

As with RJ, the **DVOMB prohibits Couples Counseling during domestic violence offender treatment**. Section 5.09 of the **DVOMB** *Standards and Guidelines* specifies that **the offender—not the couple or the relationship—is the treatment client**, and that **conjoint sessions are not permitted** while the offender is in treatment. This prohibition reflects concerns about victim safety, unequal power dynamics, and the statutory mandate that treatment prioritize **offender accountability** over relational adjustment. The present review was undertaken to revisit the evidence base as part of a review by the **Standards Revision Committee**, with attention to whether recent research alters the policy landscape, and whether couples counseling warrants consideration as a **supplemental practice** under narrowly defined conditions.

Effectiveness of Couples Counseling in Domestic Violence Contexts

Research on **Couples Counseling** for **domestic violence** has grown in recent years, though the overall evidence base remains small, methodologically constrained, and concentrated in select populations. The **strongest positive findings come from specialized military interventions**. Multiple randomized controlled trials of the Strength at Home—Couples (SAH-C) program have demonstrated **reductions in physical, psychological, and sexual aggression**, alongside decreases in coercive control and suicidality. These outcomes were consistently more favorable than those of supportive prevention conditions, suggesting that structured conjoint interventions delivered by trained clinicians under explicit protocols can produce measurable improvements in relational and safety outcomes (Taft et al., 2016a; Taft et al., 2021; Taft et al., 2024).

Outside of military contexts, evidence is more tentative. Large randomized trials of online relationship programs, including OurRelationship and ePREP, showed improvements in relationship satisfaction and **modest reductions in IPV** among low-income couples when compared to waitlist controls (Doss et al., 2020). Subgroup analyses of military couples suggested additional declines in IPV over time, though these **were not significantly greater** than in control groups (Salivar et al., 2020). Similarly, community-based evaluations of couples experiencing **low-intensity violence** found that participants in web-based interventions reported moderate gains in relationship quality, though **effects on actual violence were small and uncertain** (Roddy et al., 2017; 2018). Treatment-as-usual evaluations with veteran couples also showed reductions in distress and IPV over follow-up (Nowlan et al., 2017), though such studies lacked strong comparison groups.

In contrast, one of the few studies directly comparing conjoint and individual treatment suggested **potential risks of integrating couples therapy into higher-need contexts**. In this trial with substance-involved women and their partners, individual behavioral therapy (IBT) was more effective than behavioral couples therapy (BCT) combined with IBT, yielding greater reductions in psychological aggression, physical assault, injuries, and sexual coercion (Schumm et al., 2018). These findings indicate that conjoint approaches may not only fail to outperform individual treatment in this context but could also **dilute the effectiveness of offender-focused interventions** in complex cases.

Despite these occasional promising signals, the broader evidence base is undermined by recurring methodological weaknesses:

- Most studies **exclude couples experiencing severe violence**, non-fatal strangulation, weapon use, or entrenched coercive control, meaning that findings apply primarily to **lower-risk or situational violence** rather than to justice-involved populations where dynamics are typically more severe and chronic.

- Nearly all evaluations rely heavily on **self-report surveys**, despite well-documented risks of underreporting and social desirability bias (Heckert & Gondolf, 2000; Archer, 1999; Gondolf, 2002). Few incorporate survivor-defined outcomes or official records. **Small sample sizes**, **high attrition**, and **voluntary recruitment** further **constrain generalizability**, as do the predominance of White, heterosexual, and military populations in the available data.

- **Long-term follow-up is rare**, leaving questions about whether reductions in DV persist over time. Finally, many trials compare conjoint interventions against minimal-service controls, rather than against established group or individual treatments, making it difficult to evaluate added value.

Another critical gap lies in the **lack of research** on **how Couples Counseling might interact with or complement existing offender treatment**. Current **DVOMB** *Standards and Guidelines* prohibit conjoint therapy during mandated treatment, emphasizing that the **offender**—not the relationship—is the treatment client. Yet in practice, some couples wish to remain together, and others will enter new relationships following treatment. Whether carefully designed, survivor-centered **Couples Counseling** could serve as an **adjunct or follow-on** to standard offender treatment remains unexplored. Such models might conceivably support **safer communication**, **reinforce non-violent relationship skills**, or **promote healthy relational functioning** once offenders have demonstrated sustained accountability and behavioral change. However, no empirical studies have tested conjoint approaches in this way.

In summary, the evidence on **Couples Counseling** in domestic violence contexts is mixed, context-bound, and methodologically weak. Programs like SAH-C show potential benefits in narrowly defined military settings, and some online interventions demonstrate modest effects for low-intensity IPV. But **generalizability to higher-risk, justice-involved populations is poor**, risks to survivor autonomy and safety remain inadequately addressed, and the role of conjoint therapy as an adjunct or follow-on to offender treatment is an open and important question for future research.

Synthesis and Policy Implications

The cumulative evidence suggests that **Couples Counseling** can, under tightly controlled conditions, reduce **low-level domestic violence** and **improve relationship functioning** in certain lower-risk populations. The most consistent positive findings come from military-focused programs like Strength at Home—Couples (SAH-C), where specialized clinicians, systematic screening, and structured protocols are integral to delivery. Similarly, online interventions such as OurRelationship and ePREP demonstrate modest benefits for community couples with low-intensity domestic violence. Yet these findings are context-specific and **cannot be generalized to the court-mandated populations** served by Colorado's **DVOMB** treatment system, where higher levels of coercive control, chronic abuse, and complex safety risks are common.

One important but unexplored area is the potential role of **Couples Counseling** as an adjunct or follow-on to domestic violence offender treatment. In cases where couples choose to remain together—or where offenders enter new relationships following treatment—structured, survivor-centered conjoint work could theoretically reinforce non-violent relational skills and support healthier communication once accountability milestones are met. While conceptually attractive, n**o empirical studies have tested this sequencing**, and critical questions remain regarding feasibility, safety, and effectiveness. Until such evidence is available, any integration of conjoint practices into Colorado's regulated treatment framework would be premature.

For Colorado, the current evidence **supports maintaining the DVOMB's general prohibition on Couples Counseling during domestic violence offender treatment**. However, given emerging though limited findings from military and community settings, the **DVOMB** may wish to begin structured **committee-level discussions about the potential for adjunct** or **follow-on use** of Couples Counseling during the **final maintenance phase** of treatment under narrowly defined circumstances. Any loosening of standards would require careful deliberation, standards review, and a phased approach, with the understanding that such interventions could only be considered when **survivors voluntarily opt in**, offenders have demonstrated **substantial treatment progress**, and cases are assessed as lower risk. This exploration would also necessitate consideration of specialized provider training, systematic safety screening, and embedded evaluation protocols.

Key Takeaways: Couples Counseling in DV Offender Treatment

- **Evidence is limited and mixed.** Conjoint interventions show modest benefits in lower-risk or military populations, but findings are inconsistent and not generalizable to justice-involved offenders.
- **Methodological weaknesses persist.** Studies often exclude severe cases, rely heavily on self-report, use small samples, and compare against minimal controls, limiting confidence in results.
- **Survivor safety is paramount.** Risks of coercion, silencing, and retaliation remain significant, and survivors frequently prefer individual over conjoint counseling.
- **Context matters.** Positive outcomes are most evident in military programs under specialized conditions not present in Colorado's community-based offender treatment system.
- **Adjunct/follow-on models remain unexplored.** Research has not yet tested whether Couples Counseling could play a role after offender treatment to support couples who remain together or to guide healthy behaviors in new relationships.
- **Policy implications are clear.** Couples Counseling is not generally appropriate in domestic violence offender treatment, and the **DVOMB's prohibition** remains consistent with current evidence and statutory mandates. At the same time, committee-level discussions may be warranted to consider whether limited adjunct or follow-on options could be appropriate in narrowly defined, lower-risk situations or after substantial treatment progress. Any such development would require specialized provider training, careful safety screening, and embedded evaluation protocols.

Final Synthesis: Implications for Research-Informed Best Practices

The reviews of **RJ** and **Couples Counseling** reinforce the **DVOMB's** core position that domestic violence treatment must prioritize **survivor safety**, maintain **offender accountability**, and follow the principles of **RNR**. While both approaches show some promise in narrow contexts, methodological weaknesses and safety concerns prevent their generalization to Colorado's court-mandated populations. As of **FY 2025**, the evidence does not justify changing existing statutory or standards-based prohibitions on conjoint work during treatment. Stakeholder input from **victim advocacy representatives** has also consistently **emphasized strong opposition to restorative or conjoint interventions** as standard practice.

At the same time, the **DVOMB** remains committed to evidence-informed innovation. The reviews suggest that if considered at all, **RJ** and **Couples Counseling** should only be explored as **tightly controlled**, **supplemental options** after substantial offender progress, with s**urvivor opt-in**, **clear safeguards**, and **MTT oversight**. Any pilot would require careful standards review, specialized training, and robust evaluation using the **PDMS** to track safety, outcomes, and effectiveness. Until stronger evidence emerges, the best-supported path to reducing reoffending and protecting survivors remains ensuring **treatment integrity**—qualified providers, adherence to RNR, and strong oversight across Colorado's domestic violence offender treatment system.

DVOMB Data Analysis

Data Collection Overview

The Colorado Legislature passed House Bill 22-1210 in June 2022 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.[2] Given the high subscription rate, the **DVOMB** partnered with ReliaTrax to integrate the data collection requirements to avoid duplicate data entry efforts.

Data collection began on January 1, 2023. As **DVOMB** Approved Providers implement this new requirement, **ongoing technical assistance** for data collection has been offered.[3] **DVOMB** Approved Providers submit data for each treatment episode for each individual client. The **DVOMB** presents findings in aggregate form; **individual provider data or outcomes cannot be isolated**. 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 2025** and were submitted between **July 1, 2024, and June 30, 2025**. The current reporting period represents the second full year of data collection and is referred to as **Year 2**. Data previously reported for the first six months of data collection in the DVOMB 2024 Annual Legislative Report is referred to as **Year 0** and data reported for the first full year in the DVOMB 2025 Annual Legislative Report is referred to as **Year 1**.

Background and Client Characteristics

For the **12-month period running July 1, 2024 to June 30, 2025**, Approved Providers submitted **4,313** client records. The PDMS was used for **286 records (6.6%)**, while ReliaTrax for **4,027 (93.4%)**.

[2]At the time the data collection plan was developed, 86% of the **DVOMB** Approved Providers were subscribed to ReliaTrax.

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

The **final dataset contained 4,260 client records** as a small number of records (53 in total) 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 amount of data submitted was significantly greater than expected compared to the 437 records submitted for the six-month implementation phase (Year 0) and 1,994 data from last year (Year 1). The records contained clients from all **23 Judicial Districts** in Colorado, an increase from the 16 districts represented in Year 0 and 21 districts from Year 1. Clients residing in El Paso, Adams, Denver, Arapahoe, Jefferson, and Weld counties accounted for the largest number of records during the past year (Year 2). Client consent to share personal identifying information for future recidivism tracking experienced a moderate increase to **83%**, up from 78% in Year 1 and 47% in Year 0.

Table 1A and 1B display the demographic characteristics of clients seen in FY 2025. As shown in **Table 1A**, most clients were **male**, while **20.5%** were **female**. The average age was **34**, ranging widely from **18 to 84 years**. Most clients identified as heterosexual, while 5.8% (compared to 4% in Year 1) identified as having diverse sexual orientations. Client race-ethnicity was **50% White** (compared to 53% in Year 1), **34% Hispanic-Latino**, and **11% Black or African American**.[4] Other racial-ethnic groups accounted for **4.5%** of the clients. It is important to note that this data does not fully capture information regarding individuals identifying as multiple racial or ethnic groups, as the data entry system is restricted to a single selection. **English** was the primary language spoken by most clients (**87%**), followed by **Spanish (12%)**. As shown in **Table 1B**, nearly **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.

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

- **30%** (compared to 29% in Year 1) were **separated**
- **26%** (down from 28% in Year 1) were **formally married** or in a common-law marriage
- **25%** (compared to 24% in Year 1) were in an **exclusive relationship**
- **17%** (compared to 18% in Year 1) were **dating**
- **1%** (compared to <1% in Year 1) were in an **open relationship**
- **1%** were in a relationship that is not listed here
- **<1%** (no change in Year 1) were **formally divorced**
- **<1%** (no change in Year 1) were **widowed**

[4] Of the 1,336 Hispanic-Latino clients, 83% were of Mexican origin.

Table 1A: Client Demographics FY 2025.

Client Characteristic (N = 4,260)	Count (%) / Mean (Range)
Gender	—
Male	3,363 (79%)
Female	874 (21%)
Transgender Male	12 (0.3%)
Non-Binary	6 (0.1%)
Transgender Female	*
Intersex	*
Missing	*
Sexual Orientation	—
Heterosexual	4,015 (94%)
Bisexual	82 (1.9%)
Lesbian	67 (1.6%)
Gay	55 (1.3%)
Pansexual	19 (0.4%)
Self-identify	15 (0.4%)
Asexual	5 (0.1%)
Questioning	*
Missing	*
Race/Ethnicity	—
White	1,963 (50%)
Hispanic	1,282 (33%)
Black or African American	440 (11%)
Native American or American Indian	88 (2.2%)
Asian or Pacific Islander	54 (1.4%)
Latino	54 (1.4%)
Not listed here	35 (0.9%)
Missing	344
Hispanic Origin	—
Not Hispanic Origin	2,285 (60%)
Mexican	1,107 (29%)
Not Listed Here	350 (9.2%)
Puerto Rican	40 (1.1%)
Latino	18 (0.5%)
Missing	460
Age (At Time Of Offense)	34 (18 - 84)

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

Table 1B: Client Demographics FY 2025 Cont.

Client Characteristic (N = 4,260)	Count (%) / Mean (Range)
Primary Language	—
English	3,319 (87%)
Spanish	470 (12%)
Not listed here	11 (0.3%)
Missing	460
Highest Education (At Time of Offense)	—
High school degree or equivalent (e.g., GED)	1,933 (51%)
Less than high school degree	991 (26%)
Bachelor degree	348 (9.2%)
Associate degree	204 (5.4%)
Vocational schooling	199 (5.2%)
Graduate degree	96 (2.5%)
Some college but no degree	24 (0.6%)
Doctoral degree	5 (0.1%)
Missing	460

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

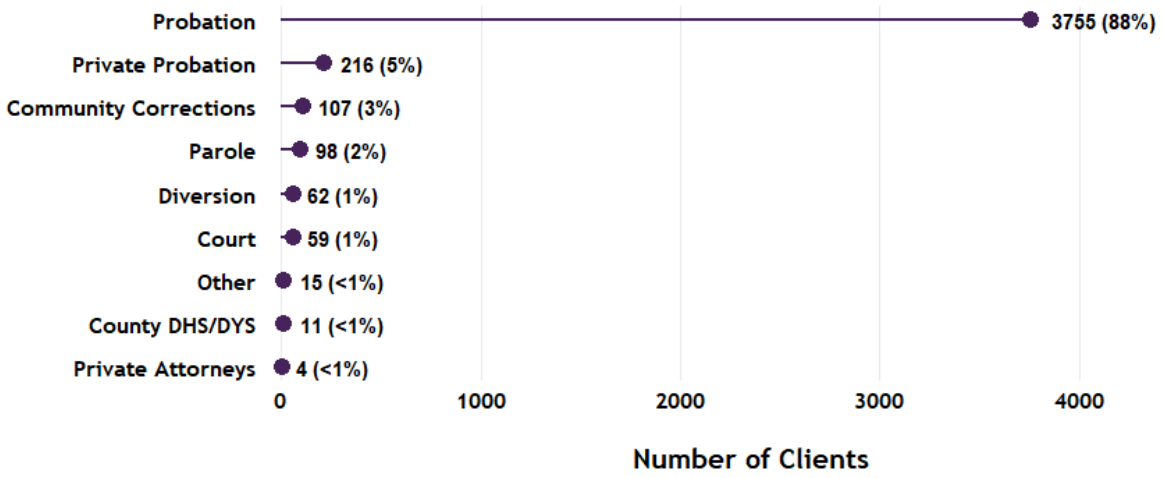
Regarding clients' **prior convictions for domestic violence** and **prior domestic violence treatment**:

- **35%** (up from 32% in Year 1) had prior domestic violence incidents not reported to the justice system
- **27%** (compared to 26% in Year 1) had **violations of an order of protection**
- **26%** (compared to 29% in Year 1) had **prior domestic violence convictions**
- **22%** (vs. 24% from Year 1) had **prior domestic violence treatment**
- **18%** (vs. 12% in Year 1) had **past or present civil domestic violence-related protection orders**
- **17%** (vs. 16% in Year 1) had **prior arrests for domestic violence**

Additionally, 11% of clients were sentenced to **unsupervised probation** before starting domestic violence offender treatment, compared to 12% in Year 1 and 5% in Year 0.

Figure 1 shows the referral sources for clients attending domestic violence offender treatment. As shown, **probation** referred most clients.

Figure 1: Referral Sources, FY 2025 (Count 4,259). Data table, Appendix A.



Note: Percents do not add 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:

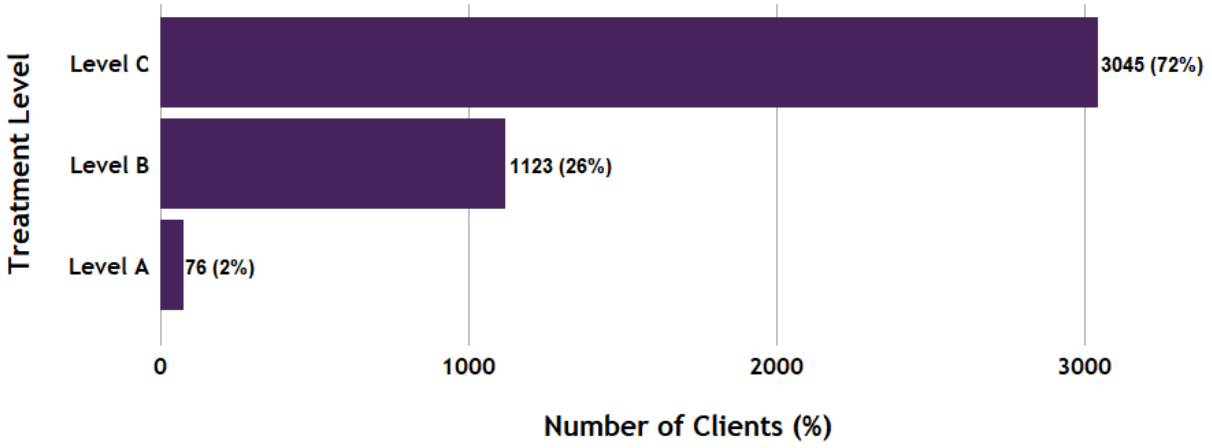
- Law Enforcement Summary Reports (**96%**)
- Criminal History Summary (**71%**, down from 82% in Year 1)
- Victim Statements (**19%**, down from 30% in Year 1)
- Substance Abuse Evaluations (**8%**, compared to 5% in Year 1)
- Previous Domestic Violence Offender Evaluations (**4%**, compared to 5% in Year 1)
- Mental Health Records (**4%**)
- Other Documents (**8%**)

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 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.

The **DVOMB** Approved Provider consults with the **MTT** regarding the **DVRNA results** when determining the appropriate treatment placement 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 2**, 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 classified as **Level A**, the lowest intensity option. Additional data also indicated that most clients (85.3%) maintained the same treatment placement level through therapy. Treatment placement levels **decreased for 13%** (down from 17% in Year 1) of clients and **increased for 1.5%**.

Figure 2: Distribution of Treatment Levels, FY 2025 (Count 4,244). Data Table 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:[5]

- **40%** (compared to 43% in Year 1) for **mental health treatment**.
- **36%** (compared to 37% in Year 1) for **substance abuse treatment**.
- **25%** (compared to 22% in Year 1) for an **unspecified** second contact.
- **12%** (compared to 10% in Year 1) for **Moral Reconation Therapy (MRT)**.
- **<1%** (no change from Year 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.[6] Approved Providers assessed responsivity factors through the **therapeutic alliance** (48%), **client feedback** (74%), **collateral contacts** (45%, down from 55% in Year 1), and identifying the topic of treatment sessions (40%).

[5] Percentages do not sum to 100% because multiple second contact referrals are possible.

[6] 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.

Approved Providers identified the following **responsivity barriers** during treatment:

- Client Factors (**28%**, up from 25% in Year 1)
- Finances (**19%**, compared to 20% in Year 1)
- Terms of Supervisions (**7%**, up from 3% in Year 1)
- Employment Factors (**5%**, compared to 4% in Year 1)
- Lack of Social Supports (**5%**, down from 7% in Year 1)
- Adjunct Treatment Needs (**4%**, compared to 5% in Year 1)
- Cultural Needs (**4%**, no change from Year 1)
- Housing Issues (**3%**, no change from Year 1)
- Transportation (**3%**, compared to 2% in Year 1)
- Lack of Engagement with the Community (**2%**, compared to 3% in Year 1)
- Lack of Specific Resources (**2%**, compared to 1% in Year 1)
- Community Limitations (**1%**, compared to 2% in Year 1)
- Other (**1%**, compared to 2% in Year 1)

Approved Providers reported addressing clients' responsivity factors by:

- Offering Vouchers to Offset Fees (**17%**, down from 22% in Year 1)
- Adjusting Treatment (**11%**, up from 8% in Year 1)
- Adjusting Treatment Modalities (**10%**, no change from Year 1)
- Using External Supports (**7%**, up from 5% in Year 1)
- Adjusting Treatment Language (**6%**, up from 4% in Year 1)
- Adjusted Treatment for Culture (**5%**, up from 2% in Year 1)
- Using Specialized Resources (**2%**, no change from Year 1)
- Providing Housing and Transportation Support (**1%**, no change from Year 1)
- Using Other Supports (**1%**, no change from Year 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 all recorded discharge types—completed, unsuccessful, and administrative—**58% had completed discharges** (compared to 57% in Year 1 and 62% in Year 0), **35%** had unsuccessful discharges (compared to 37% in Year 1 and 30% in Year 0), and **7%** had administrative discharges.

As displayed in **Figure 3**, rates of successful treatment completion increase as the corresponding risk decreases by treatment placement level. Clients in **Level A** had the highest percentage of completed discharges at **84%** (slightly up from 83% in Year 1). Clients in **Level C** had the lowest completed discharge rates at **52%** (slightly up from 50% in Year 1). The significant difference in successful completion rates observed among Level C clients is likely influenced by their **higher risk levels**, greater **density of criminogenic needs**, and **motivational issues**. 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.

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 for clients with **unsuccessful discharges**. A discharge reason involving **excessive absences** was indicated for **12%** of clients (compared with 11% in Year 1 and 25% from Year 0). Of note, 18 violated the terms of conditions of supervision, 17 clients had non-compliance with monitored sobriety/drug alcohol use, 11 were unable to meet financial responsibilities, 10 were unsuccessful in progressing with core competencies, **3 had new domestic violence-related offenses**, 3 committed new non-domestic violence offenses, and 1 never attended. Additionally, 123 clients (8%) were discharged unsuccessfully for other reasons.

Figure 3: Discharge Outcomes by Treatment Level, FY 2025 (Count 4,244). Data Table Appendix A.

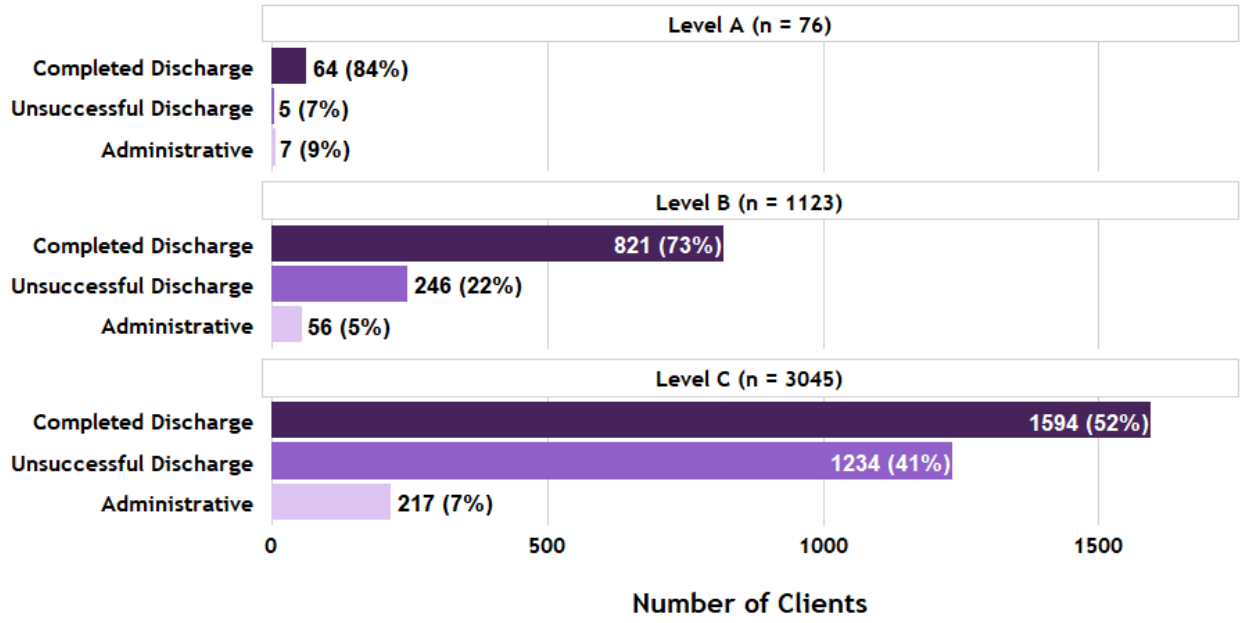


Table 2: Unsuccessful Discharge Reasons, FY 2025 (Count 1,355).

Discharge Reason	Number of Clients	Percent of Clients (%)
Unsuccessful - Administrative Other	1024	69%
Unsuccessful - Excessive Absences	183	12%
Unsuccessful – Other	123	8%
Unsuccessful - Violation of terms and conditions of supervision	18	1%
Unsuccessful - Non-Compliance with Monitored Sobriety/Drug Alcohol Use	17	1%
Unsuccessful - Violation of Treatment Plan/Contract	15	1%
Unsuccessful - Dropped out of Program/Abandoned Treatment	14	<1%
Unsuccessful - Unable to meet financial responsibilities	11	<1%
Unsuccessful - Unsuccessful in Progressing with Core Competencies	10	<1%
Unsuccessful - New domestic violence related offense	3	<1%
Unsuccessful - New non-domestic violence related offense	3	<1%
Unsuccessful - Never Attended/Failed to Begin Program	1	<1%

Treatment Duration

Treatment duration ranged from **0 to 43 months** (3.5 years). **Figure 4** displays the **treatment length broken down by treatment placement level and outcome**, illustrating patterns in client engagement and treatment completion.[7] Across all discharge types, **the median duration in treatment was 6.7 months** (slightly down from 6.9 months in Year 1), meaning that half of clients were in treatment for less than 6.7 months and half for more.

For clients who **completed treatment**, the median duration across all placement levels was **8.4 months** (slightly shorter than 9 months in Year 1). Median durations varied by placement/risk levels in a pattern consistent with both the structure of the *Standards and Guidelines* and research indicating that higher risk clients require a greater dosage of treatment:

- **Level C (high risk)**: median **8.7 months** (down from 9.4 months in Year 1).
- **Level B (moderate risk)** and **Level A (low risk)**: progressively shorter durations.

In contrast, treatment duration for **unsuccessful discharges** was significantly shorter, particularly among higher risk clients:

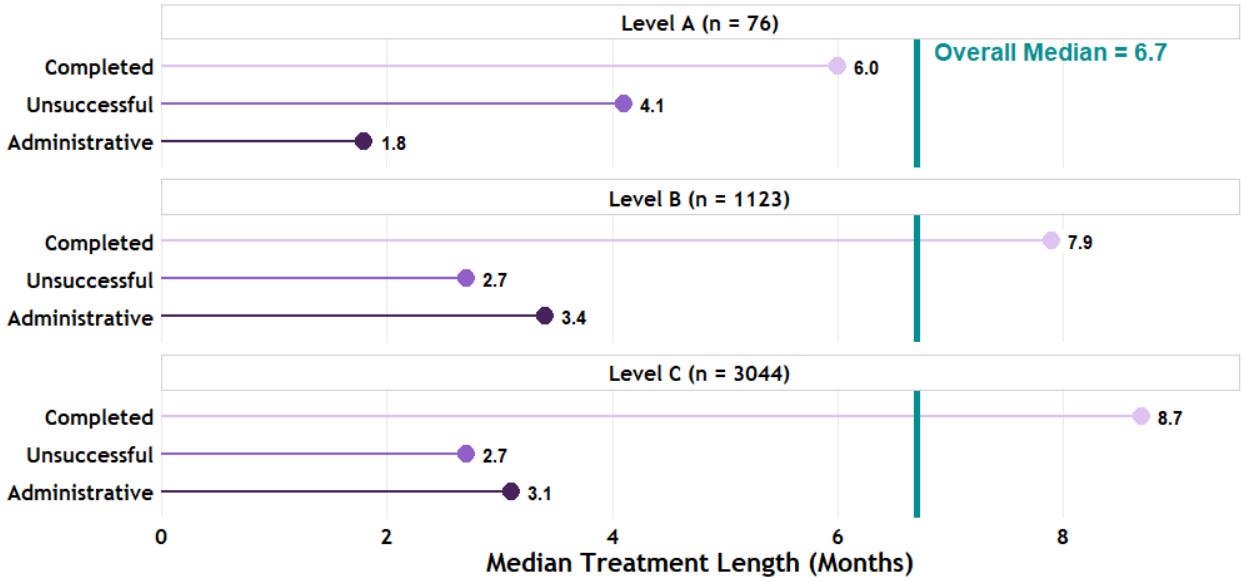
- **Level B (Count = 1123):** median **2.7 months** (similar to 2.8 months in Year 1).
- **Level C (Count = 3044)**: median **2.7 months** (similar to 3.0 months in Year 1).

These truncated durations indicate that many higher-risk clients disengage—or never meaningfully engage—**within the first 90 days of treatment**. This early attrition aligns with the domestic violence treatment literature, which links noncompliance to **motivational challenges**, **lifestyle instability**, and **ongoing risk-related behaviors**. While the *Standards and Guidelines* include clear requirements for attendance monitoring and absence reporting, and these measures may have a positive impact in many cases, **monitoring alone does not appear sufficient to overcome the engagement barriers** commonly observed among higher-risk clients.

Given the concentration of early dropout, DVOMB staff plan to conduct additional research to identify the **drivers of early non-completion** as well as the **factors associated with success** among higher-risk clients who do complete treatment. This work will include analyses of **treatment dosage, modality, and contextual qualitative data** captured through Approved Providers' comments in the PDMS. Further analyses will also examine **post-discharge system outcomes**, including re-referral to other Approved Providers within the same community sentence and the extent to which **legal consequences follow unsuccessful discharges**.

[7] The treatment length for one extreme outlier client (over 10 years) was set to missing to avoid skewing statistical results.

Figure 4: Treatment Length by Treatment Level, FY 2025 (Count 4,243). Data Table Appendix A.



Treatment Absences

Consistent attendance in treatment sessions provides structure and ensures clients address treatment areas to effectively reduce their risk. In **FY 2025**, attendance showed minor changes from prior years: **15% missed no sessions** (up from 12%), **27% missed one to three times** (down from 29%), and **61% missed four or more times** (up from 60%), with the average being **seven absences**. Excessive absences are a well-documented barrier to client engagement and effective risk reduction in this field.[8] Statistical analyses revealed two key associations: **greater treatment absence was linked to higher risk levels**, while **fewer absences were associated with using in-person only modalities** compared to mixed or teletherapy. Although the *Standards and Guidelines* permit excused absences, excessive absences disrupt continuity and are often reported as a direct cause of early treatment termination.[9]

Treatment Modalities

The *Standards and Guidelines* mandate **group treatment sessions** as the preferred modality with individual sessions used on a case-by-case basis. Likewise, **in-person treatment is preferred over teletherapy** unless it is in the client's best interests to have access to treatment virtually. In **FY 2025**, treatment delivery showed an **increasing reliance on in-person modalities**: **59%** received in-person sessions only (group or individual; up from 45% in Year 1 and 54% in Year 0), **31%** received teletherapy only (teletherapy group, individual teletherapy, or teletherapy for medical or weather-related emergencies (down from 45% in Year 1 and 34% in Year 0), and **10%** received mixed modes of both in-person and teletherapy (similar to 9% in Year 1 and 12% in Year 0).

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

[9] Exceeding three absences triggers a mandatory MTT consultation to determine consequences or modifications to the Treatment Plan. All offender absences must be reported within 24 hours to the Treatment Victim Advocate and the referring agency, and the MTT may require documentation of reasons for absences.

The specific treatment modalities were:[10]

- **65%** received in-person group therapy
- **12%** received in-person individual sessions
- **38%** received teletherapy group (down from 52% in Year 1 and 44% in Year 0)
- **5%** had individual teletherapy (down from 8% in Year 1 and 15% in Year 0)
- **<1%** (7 providers) had teletherapy for medical or weather-related emergencies.

Note that while clients can receive more than one treatment modality, providers reported that they used one modality only in 90% of cases, and two to five modalities in 9% of cases.[11]

Limitations

The **DVOMB data analysis** included in this report provides the second full year of data collection following the implementation of the data collection mandate. The data submission rate has **more than doubled from Year 1**, signifying greater awareness among the providers about the PDMS and data entry. **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 second full year of data collection (**Year 2**) represents a significant milestone, with **4,260 client records** submitted across all 23 Judicial Districts. This significantly expanded dataset reflects the **maturation of the PDMS data collection process** and the strong commitment of Approved Providers to evidence-based practice, as demonstrated by an **83% client consent rate** for future research.

The data show that Approved Providers are operating in **alignment with the RNR model**. Fidelity to the **Risk and Need Principles** begins with timely assessment: **92 percent of clients** receive a DVRNA risk-need assessment within 30 days of referral. Most clients receive a high-risk **Level C** placement, reflecting the high concentration of **criminogenic needs** among those referred to treatment. Consistent with the **Risk Principle**, these higher-risk clients receive the longest treatment duration, with a median completion time of **8.7 months**, ensuring the dosage necessary for complex needs. Providers are also meeting expectations regarding adjunct services (**Second Contacts**), with **mental health (40 percent)** and **substance use (36 percent)** referrals predominating. In accordance with the **Responsivity Principle**, providers demonstrate flexibility by offering **tailored adjustments**—such as financial vouchers and modifications to treatment language or modality—while actively addressing barriers to client factors and financial constraints.

[10] Percentages exceed 100% as some clients may receive their treatment using two or more modalities (e.g., in-person group sessions and teletherapy group sessions).
[11] 1% of clients had missing modality data.

Key themes and significant findings from this year's data include:

- **Demographics and Responsivity:** The client population shows marked diversity across age, race/ethnicity, gender—including greater sexual and gender diversity (**5.8%**, up from 4% in Year 1)—and educational background. Approximately **13%** have a primary language other than English. This diversity underscores the need for individually responsive care and affirms the **DVOMB's** investment in the **Responsivity Principle** of the RNR model.

- **Early Attrition:** A major concern is the persistent pattern of **early attrition** among higher-risk clients, where the median duration for unsuccessful discharge is only **2.7 months**. This trend points to underlying motivational issues, lifestyle instability, and active risk-related behaviors that impede engagement. It underscores a core challenge in domestic violence offender treatment: effective treatment and public safety depend on clients remaining engaged long enough to influence risk factors, abusive behavior patterns, and ultimately their likelihood of reoffending. Given this concentration of early dropout, DVOMB staff will conduct additional research to identify the **drivers of early non-completion** and **factors associated with success** among higher-risk clients who do complete treatment. This will include examining **post-discharge system outcomes**, such as re-referral to other Approved Providers within the same community sentence and the extent to which **legal consequences follow unsuccessful discharges**.

- **Modality & Attendance:** The field-wide shift toward **in-person treatment** (**59%** of providers) aligns with **DVOMB** policy and is significantly associated with **fewer client treatment absences**, demonstrating the positive impact of appropriate treatment modality on client retention.

The continuous monitoring enabled by this robust data collection process confirms that the *Standards and Guidelines* remain a **foundational framework** for domestic violence intervention in Colorado. The **PDMS** not only provides extensive quantitative data demonstrating provider **adherence to the RNR model**, but also captures a rich layer of **optional qualitative comments** on critical decision points. The **DVOMB** will leverage this expanded quantitative and qualitative foundation to conduct **higher-level analyses** and **inform targeted adjustments** to the *Standards and Guidelines*. This comprehensive data will also serve as the crucial **baseline for measuring the impact of future changes**, ultimately ensuring **evidence-based treatment** that effectively serves offenders, victims, and public safety.

Section 2: Relevant Policy Issues and Recommendations

Background

Pursuant to HB 22-1210, the sunset renewal of the **DVOMB** included language authorizing the **DVOMB** to make **policy recommendations** to the legislature as part of its annual report. In addition, the **DVOMB** may **highlight key court decisions and developments of interest** to the legislature due to their potential impact on the Board's statutory responsibilities and the broader field of domestic violence intervention. While some topics may extend beyond the Board's **direct purview**, domestic violence intersects with numerous policy arenas, stakeholders, and institutions working to reduce intimate partner violence. Within this context, the **DVOMB** aims to support informed policymaking and the continued improvement of domestic violence prevention and intervention services across Colorado.

The following section therefore presents:

- Discussion of use of **pre-trial diversion in domestic violence offender cases**, with considerations and recommendations outlined, and
- Review of the recent Colorado Supreme Decision: ***People v. Crawford (24SA226)***.

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.

Domestic Violence Cases in Diversion Programs and the Statutory Purview of the DVOMB

Introduction

Diversion programs in Colorado offer a voluntary alternative to traditional criminal proceedings, allowing a defendant to avoid entering the criminal legal system upon successful completion of program requirements. While domestic violence cases have not been historically considered for pre-trial diversionary programs, several jurisdictions are now expanding these programs to include domestic violence cases. Pursuant to **§ 16-11.8-103(4) C.R.S.**, the **DVOMB does not have statutory purview over diversionary cases** without a **deferred sentence** involving domestic violence. Despite this lack of statutory authority, diversion programs frequently rely on **DVOMB** Approved Providers to provide evaluation and treatment services to clients on diversion.

The following policy discussion examines use of **pre-trial diversion** for domestic violence cases and how this intersects with the **roles and responsibilities** of the **DVOMB**. The discussion focuses on current **statutory requirements**, the role of evidence-based **risk assessment**, the characteristics of individuals most **appropriate** for diversion, and areas of incongruence with the existing **DVOMB** approach to treatment for domestic violence offenders. To frame this analysis, several important considerations guide the discussion:

1. **Diversion is generally appropriate for low-risk individuals** who demonstrate stability and prosocial functioning in the community (Cox & Rivolta, 2014; Radatz et al., 2021). It is generally **not suitable** for those at **moderate** or **high** risk, who present with greater instability, elevated safety concerns, and **more complex treatment needs**. Applying pre-trial diversion to higher risk cases contradicts the RNR principles, which require matching the intensity of supervision and treatment to an individual's risk and need level.

2. **Accurate risk assessment requires specialized training and the use of validated assessment instruments.** Determining risk level is a specialized task that involves far more than reviewing the index offense or charge description; it relies on validated tools administrated as part of a comprehensive evaluation.The offense alone rarely reflects the person's actual risk to the victim or the community.

3. **The DVOMB currently lacks statutory authority over pre-trial diversion programs,** resulting in limited regulation, oversight, program requirements, and training across jurisdictions.

Background and Statutory Context

Diversion is a voluntary alternative to court proceedings, typically occurring at the county or district court level, with a primary goal of community safety. A successful completion results in the **dismissal of all criminal charges with prejudice**, an outcome explicitly not considered a conviction for any purpose. District Attorneys' (DAs) offices are authorized by **§ 18-1.3-101 C.R.S.** to develop and implement these programs, which aim to prevent future criminal acts, facilitate victim restoration and restitution payments, and reduce the volume of cases in the criminal legal system. Additionally, they allow defendants to avoid the collateral consequences associated with criminal charges and convictions.

Subsection (5) of the statute specifically states:

> *"(5) In a jurisdiction that receives state moneys for the creation or operation of **diversion programs** pursuant to this section, an individual accused of an offense, the underlying factual basis of which involves domestic violence as defined in section 18-6-800.3(1), is not eligible for pretrial diversion unless charges have been filed, the individual has had an opportunity to consult with counsel, and the individual has **completed a domestic violence treatment evaluation**, which includes the use of a domestic violence risk assessment instrument, conducted by a **domestic violence treatment provider approved by the domestic violence offender management board** as required by **section 16-11.8-103(4), C.R.S.** The district attorney may agree to place the individual in the diversion program established by the district attorney pursuant to this section if he or she finds that, based on the results of that evaluation and the other factors in subsection (3) of this section, the individual is appropriate for the program."*

In jurisdictions that receive state funding for a **diversion program**, the statute specifies three requirements that must be met for an individual accused of a domestic violence offense to be eligible:

- Charges have been filed.
- The individual has consulted with counsel.
- A **domestic violence treatment evaluation**, including a **risk assessment instrument**, must be completed by a **DVOMB Approved Provider** as required by **§ 16-11.8-103 (4) C.R.S.**

While the **District Attorney (DA)** retains **sole discretion** to determine an individual's appropriateness for the program based on the evaluation and other case factors, **DVOMB** Approved Providers retain the discretion regarding if and how they would like to deliver services to clients on diversion. While the initial evaluation must be conducted by a **DVOMB** Approved Provider (per § 18-1.3-101(5) C.R.S.), this requirement **does not extend the purview of the DVOMB**, and the **DVOMB** cannot create standards or instill requirements for **DVOMB** Approved Providers to follow.

Pursuant to § 16-11.8-103 (4) C.R.S., the **DVOMB's** authority is designated to:

> *"offenders who have committed a crime, the underlying factual basis of which has been found by the court on the record to include an act of domestic violence, and who are placed on **probation**, placed on **parole**, or placed in **community corrections** or who receive a **deferred judgment and sentence**."*

Policy Analysis: The RNR Model and the Low-Risk Population

The growing use of **diversionary programs** for domestic violence cases reflects prosecutors' efforts to expand options to address a range of community needs. For instance, some programs utilize diversion to ensure that defendants, who might otherwise have their cases dismissed without any intervention, receive some form of targeted services to address their behavior. Conversely, some jurisdictions prioritize domestic violence cases for defendants charged with **low-level**, **non-violent offenses**, or those with **no criminal history**.

While these approaches aim to **balance accountability with public safety**, they also raise important questions about how to appropriately identify and assess which cases are suitable for diversionary programs. The nature of domestic violence typically occurs behind a veil of secrecy, with the onset of any known violence or abuse dynamics beginning with emotional, psychological, or financial forms of abuse. These non-violent forms of abuse are central to **coercive control**, such that the identification of cases based on the **index offense only** may overlook important contextual factors. **The risk of re-offending is not reliably assessed solely by the criminal charge**. A potential challenge with using diversionary programs for domestic violence cases is how to approximate the risk of the defendant that can screen for general, specific, and lethal factors to the victim and the broader community.

In **2010**, the **DVOMB** modified its *Standards and Guidelines* to replace the former 36-week model of treatment with a **differentiated model based on the principles of RNR**. This model removed time as the key function for determining progress and instead used **competencies** as the proximal measure toward the goal of reducing attitudes and behaviors under which coercive control persists. The model introduced **three levels**—Level A (low intensity), Level B (moderate intensity), and Level C (high-intensity)—in an attempt to design a system that distinguishes and responds differently to populations based on their **risk of reoffending**.

The **RNR model** is premised on a comprehensive evaluation conducted by a **DVOMB** Approved Provider. The purpose of this evaluation is to:

- Assess a client's need for treatment and determine what type of treatment is required.
- Identify the client's **risk level** and any additional needs.
- Ensure treatment recommendations are based on a **comprehensive evaluation**, in which the Approved Provider reviews all assessment and screening results, collateral information, and clinical interview data to determine the initial treatment level (A, B, or C).
- Ensure all offenders are evaluated using the **Domestic Violence Risk and Needs Assessment (DVRNA)**, a research-informed instrument composed of 14 risk factors used to classify individuals so treatment intensity is matched to their risk profile.

Profile and Characteristics of a Level A Offender

The profile for a low-risk, Level A offender is well-defined by the *Standards and Guidelines* and determined by the DVRNA:

- **DVRNA Criteria:** The population identified as Level A at initial placement generally **does not have an identified pattern of ongoing abusive behaviors**. They typically have a pro-social support system, minimal criminal history, and no initial evidence of substance abuse or mental health instability.
- **Risk Factors:** Level A placement is typically assigned to individuals with **one or zero risk factors** identified on the DVRNA.
- **Exclusionary Factors:** If the DVRNA identifies a **Significant Risk Factor** (such as substance abuse/dependence within the past 12 months) or a **Critical Risk Factor** (such as a prior DV conviction or use/threatened use of weapons), the client must be placed at a minimum of Level B or C, making them ineligible for Level A.
- Level A offenders receive the lowest intensity level of treatment.

Since the inception of the differentiated treatment model, programmatic data collected from **DVOMB** Approved Providers consistently demonstrates that **only a small percentage of individuals convicted** of domestic violence offenses are categorized as **Level A (Low Intensity)**. This suggests the overall population referred for domestic violence offender treatment is heavily **weighted toward moderate- and high-risk levels**. In support, findings from a process evaluation conducted by the **DVOMB** in **2016** found Level A clients accounted for approximately **12%** (count = 187) of all referrals at the time of placement in treatment. Current data reported in this Annual Report indicate a smaller proportion of Level A clients, with these cases representing only **2%** (count = 76) of the total population at the time of placement into treatment (**see Section One, Figure 3, page 30**).

The small number of Level A offenders identified by the criminal legal system suggests that diversionary programs may serve a small subset of offenders. While expanding eligibility to include higher-risk populations (Level B or C offenders) can increase numbers, it introduces significant structural and policy challenges **involving the management of higher-risk cases referred to diversionary programs that are not equipped to address these populations adequately.** For example, supervision demands for higher-risk domestic violence cases can necessitate more frequent substance use testing, home visits, firearm restrictions, and location monitoring. It is well known that effectively **supervising and treating higher-risk individuals is more resource intensive, involving adjunct treatments for co-occurring issues, longer treatment lengths, and enhanced monitoring protocols.** The absence of these important components can result in under-treating or under-supervising clients.

Diversion **carries an inherent implication**—which **may inadvertently be interpreted by** the defendant, the victim, and the broader community—that **the perceived seriousness of the offense and the level of accountability expected is less**. Individuals may presume their offense was low-risk by virtue of being placed on diversion and may therefore infer that they are entitled to fewer restrictions, less monitoring, and fewer requirements from treatment. Some individuals placed on diversion may also minimize the impact of their offense, asserting it as less consequential and may contest notions about their accountability or impact. These attitudes can be a **significant barrier and delay to treatment**. Any incongruences between expectations by the defendant and program requirements may negatively impact the defendant's motivation to participate. The results of these incongruences can range from consequential to catastrophic.

Risk assessment is an ongoing process, and the length of treatment is predicated on the defendant's ability to progress through the **Treatment Core Competencies**, reduce their risk factors, and demonstrate lasting change. Research from the **DVRNA validation study** indicates that the majority of offenders evaluated are classified as **Level C** and are at the **greatest risk of recidivism within the first 24 months**. Consequently, the risk associated with Level C defendants placed on diversion can be equal to or greater than those on probation, community corrections, or prison. Given the prevalence of moderate- and high-risk individuals in the convicted population, **a significant number of individuals referred to diversion programs may also carry risk factors that require the intensive, specialized intervention of Level B or C treatment**. Providers accepting referrals from diversion report that they are, in fact, seeing individuals who present with significant risk factors, including some that would warrant a Level B or C designation.

Key Discussion Points

Treatment Length, Accountability, and Resistance

Assessing a defendant's risk for re-offending based solely on the criminal charges is often challenging in domestic violence cases. If diversion programs do not prioritize a **thorough evaluation process**, it could compromise victim safety and **result in the placement of inappropriate cases**. In Colorado, there is no assigned duration for domestic violence offender treatment. Each client’s progress is made according to their own gains with the core competencies and individualized treatment goals rather than the passage of a specific amount of time or sessions. The standard timeframe of **less than six months** often provided in diversion agreements may be **insufficient** to achieve **lasting behavioral change**, particularly for moderate- or high-risk individuals. On average, post-conviction clients needed about 8.4 months to **complete treatment**. Only Level A clients approached the 6 month range, whereas moderate and high risk clients generally needed 8 to 9 months.

Co-Occurring Issues (Second Contacts)

According to peer-reviewed research and studies by the **DVOMB**, domestic violence offenders often have **co-occurring issues** that require additional treatments beyond those related to coercive control. These additional treatments are referred to as **Second Contacts** and enhance risk reduction and the overall effectiveness of domestic violence offender treatment by providing a **comprehensive response to a client's unique risk profile**. Co-occurring issues such as substance abuse, pro-criminal attitudes, or severe mental health conditions, often termed 'second contacts,' significantly complicate the management of domestic violence cases. Addressing these co-occurring issues with higher-risk individuals (Level B and C) who are placed in diversion programs requires **resources and specialized treatment components that can exceed the scope and capacity of typical pre-trial diversion services.** This mismatch can be a significant barrier and delay to treatment.

Multi-Disciplinary Treatment Team

The **DVOMB** *Standards and Guidelines* **MTT** model is a collaborative framework; team members (e.g., Approved Provider, criminal justice agency, victim advocate) staff cases, share information, and make **informed decisions** about risk assessment, treatment placement, and behavioral monitoring. **DVOMB** Approved Providers are accustomed to this model and may require case managers in diversion programs to participate in the MTT and receive specific training on domestic violence and victim safety.

Information Gaps

The most significant information gap remains the **lack of empirical data on recidivism** for domestic violence offenders who participate in and complete Colorado's diversion programs. In particular:

- **DVOMB** Approved Providers are **not required** to submit data for pre-trial diversion participants, creating a **systemic gap** in evaluating long-term public safety effectiveness of these programs.
- The **absence of DVOMB oversight** for diversion cases creates uncertainty regarding the fidelity of the intervention and the management of high-risk cases.
- If diversion **records are sealed**, a client's complete history is obscured, which compromises the accuracy of future risk assessments should they re-offend.

Core Policy Recommendations

To ensure public safety, integrity of the **DVOMB** structure, and maximize the effectiveness of taxpayer resources, the following core policy changes are essential for domestic violence diversion cases:

1. **Standardized Assessment Process:** Consider the use of a standardized, validated risk assessment tool (currently **DVRNA**, transitioning to **CASCADE**).
2. **Formal Accountability Structure:** Develop a clear process where the prosecutor and the MTT are immediately **notified** if a client on diversion begins engaging in **risk-related behavior**, violates any treatment or supervision requirements, or drops out of the treatment program.
3. **Systemic Information Sharing:** Require the sharing of **important information** about the diversion client regarding their evaluation results and progress in treatment.

For Approved Providers

The following recommendations are provided (**Table 3**):

Table 3. Recommendations About Diversion for DVOMB Approved Providers.

Recommendations For Approved Providers
1. Consider the **DVOMB *Standards and Guidelines* as a best practice guideline** and apply them based on their professional judgement and discretion for adults placed on diversion.
2. Carefully review any **contractual requirements** from a diversion program before accepting clients. If any concerns arise, it is important to clearly outline expectations related to their role and treatment programming.
3. Consider continuing the practice of **submitting data to the DVOMB on diversionary cases** to aid with future research regarding what populations are being referred to diversion programs and how well those populations perform while on diversion.

For Prosecutors and District Attorneys

The following recommendations are provided (**Table 4**):

Table 4. Recommendations About Diversion for Prosecutors and District Attorneys.

Recommendations For Prosecutors and District Attorneys
1. Refer to a **DVOMB Approved Provider** to conduct an offender evaluation.
2. Contemplate the appropriateness for diversion after the completion of the offender evaluation, which includes the results of the **DVRNA**
3. Ensure case managers have training and understanding of their roles and responsibilities in the **Multi-Disciplinary Treatment Team.**
4. Establish clear **program requirements and accountability structures** that allow for recourse that can bring forward charges if the diversion client begins engaging in risk-related behavior, violates any treatment or supervision requirements, or drops out of the treatment program.
5. Consider diversion agreements for a period of **12 months**.
6. **Contemplate the impact of sealed diversionary cases**, which may impact the accuracy of risk assessments if those prior records are not accessible to the Approved Provider conducting an evaluation. Although there is a benefit to incentivizing systems that can divert individuals from continued involvement with the criminal legal system, a consequence of sealing records is that it obscures an individual's prior criminal history leading to inaccurate risk assessment if reoffending occurs.
7. Notify victims of the rationale and basis for offering a diversionary program and the contact information of the Treatment Victim Advocate.

Transition to the Colorado Assessment Scale for Coercion and Abuse Desistance (CASCADE)

The **DVOMB** is currently transitioning to a new assessment called the **Colorado Assessment Scale for Coercion and Abuse Desistance (CASCADE)**, which is based upon revised improvements to the **DVRNA**. The CASCADE is divided into two main parts: one that assesses for static (historical, unchangeable) risk factors and the other that assesses for dynamic risk factors (potentially modifiable criminogenic needs linked to domestic violence). The static portion of the CASCADE tool can be used by **case managers and supervising agents** to determine the supervision level. Diversion programs may be able to use the **static portion** of the tool to perform an initial screen of individuals to help determine the appropriateness of someone for diversion prior to the domestic violence evaluation being conducted.

Conclusion

Desistance from reoffending in the context of domestic violence requires a coordinated approach that recognizes the multifaceted nature of the issue. The statutory framework limits the **DVOMB's** purview to "domestic violence offenders". While **§ 18-1.3-101 (5)** C.R.S., mandates the use of **DVOMB Approved Providers for initial evaluations** in state-funded diversion programs, this provision **does not extend the Board's regulatory authority** to the processes or individuals who have not been convicted. Any attempt by the **DVOMB** to regulate diversion programs or create standards specifically for diversionary cases would exceed its defined statutory authority.

This report aims to provide information to aid those considering diversion programs for domestic violence cases. The information provided highlights that the majority of domestic violence cases are classified as moderate or high risk (Level B or C). When these higher-risk individuals are diverted into programs lacking the mandated intensive treatment, monitoring, and accountability structures of the **DVOMB** *Standards and Guidelines*, **there is the possibility that individuals are under-supervised and under-treated**. A consequence of this could be reduced effectiveness of treatment.

Stalking: Colorado Supreme Court Decision People v. Crawford (24SA226)

Introduction

Stalking presents one of the most serious and escalating threats within the spectrum of interpersonal and domestic violence. In Colorado, the 2023 murder of Kristil Krug demonstrates how patterns of stalking can culminate in lethal violence when early intervention fails (Stelloh & Breslauer, 2025). In *People v. Daniel Krug*, it was established that Krug ambushed and murdered his wife after months of fabricating an elaborate scheme to impersonate a fictitious stalker (17th Judicial District Attorney's Office, 2025). Krug was convicted in 2025 for First-Degree Murder and Stalking (*People vs. Krug, Case No. 2023CR000581, Broomfield County, Colorado)*, resulting in a life sentence without parole. The case, which relied heavily on digital forensic evidence, highlights the need for more efficient mechanisms to access electronic communication records promptly pursuant to lawful warrants (Stelloh & Breslauer, 2025). As noted by Rebecca Ivanoff—a former prosecutor and cousin of the victim—"lawmakers should require companies to respond to stalking-related search warrants within 48 hours" (*Dateline*, as cited in Stelloh & Breslauer, 2025, p. 2).

Research consistently links stalking to a heightened risk of intimate partner homicide. Victims who are stalked by a current or former partner are several times more likely to be killed than those who do not experience stalking (McFarlane et al., 1999; Spencer & Stith, 2020; Matias et al., 2020). Beyond its association with lethal violence, stalking itself constitutes a serious and ongoing threat, defined as a repeated course of conduct that causes, or would cause, **a reasonable person to experience fear or substantial emotional distress** (Morgan & Truman, 2022). Many victims endure **prolonged stalking even after obtaining protection orders**, underscoring the challenges of enforcing existing legal remedies and coordinating timely responses across jurisdictions (Cordier et al., 2019).

National data further illustrate the scope and impact of stalking:

- Nearly **7 in 10 victims** report substantial emotional distress, and more than 6 in 10 victims fear for their safety, according to the latest National Crime Survey (Morgan & Truman, 2022).

- Tens of millions of Americans reported experiencing stalking during their lifetimes (**1 in 5 women and 1 in 10 men**)—most often by someone they knew and **frequently within intimate relationships**—as reported in the most recent National Intimate Partner and Sexual Violence Survey, 2023–2024 (Smith et al., 2025).

Together, these findings demonstrate that stalking is not an isolated behavioral issue but a pervasive, relational form of violence with profound emotional and physical consequences.

Case Overview

Against this backdrop, the **Colorado Supreme Court's decision in *People v. Crawford*, *24SA226* (May 12, 2025)**, represents a **critical clarification** in the state's stalking jurisprudence. The Court addressed the constitutional balance between protecting victims and safeguarding free expression under the First Amendment, particularly in light of the U.S. Supreme Court's ruling in ***Counterman v. Colorado (2023)***.

The ruling distinguishes between two standards:

- The ***Counterman Requirement*** (Applies to Communications): For stalking convictions based on "true threats," the prosecution must prove the defendant acted with a **subjective mental state of recklessness (i.e., mens rea)**—consciously disregarding a substantial risk that their words would be perceived as threatening violence.

- The ***Crawford Clarification*** (Applies to Conduct): The Colorado Supreme Court held that this heightened mental state requirement applies only to stalking cases based on **threatening communications**, not to cases prosecuted based on **repeated, non-speech conduct**.

This distinction provides essential guidance for prosecutors, courts, and victim advocates. It ensures that Colorado's stalking statute, **§ 18-3-602(1)(c), C.R.S.**, continues to protect victims from patterns of threatening behavior while remaining consistent with constitutional standards. The ruling has immediate and practical implications for victim safety, effective enforcement of the criminal code, and the design of domestic violence intervention and offender treatment programs statewide.

Case Description

The Colorado Supreme Court addressed whether the requirement to prove a reckless state of mind (*mens rea*), established by the U.S. Supreme Court in ***Counterman v. Colorado*, 600 U.S. 66 (2023)**, for "true threats" cases, applies to stalking charges based on a repeated course of conduct rather than the specific content of the defendant's communication.

Case Background

- **Defendant:** David Samuel Crawford.

- **Facts:** Crawford was accused in **Jefferson County** of two counts of stalking his ex-girlfriend, following the end of their relationship in 2018 and her relocation from Florida to Colorado. Despite her efforts to block his communications, Crawford persistently **contacted**, **surveilled**, and **approached** his ex-girlfriend for **over four years**. His conduct included numerous emails, phone messages, texts, social media messages, attempted communication with her friends and family, online surveillance, sending gifts, and appearing in her presence uninvited. He was arrested on May 4, 2023, after his ex-girlfriend allegedly saw him peering through her windows upon returning to her home.

- **Charges:** Crawford was charged with two counts of stalking under Colorado's repeated conduct statute, **§ 18-3-602(1)(c)**. The prosecution focused on his pattern of conduct and contacts, not the threatening nature of his speech or messages.

- **District Court Ruling:** The district court, under **Judge Diego G. Hunt**, extended the *Counterman standard*, ruling that even though the charges focused on repeated contacts (which included emails and text messages), these contacts involved speech. Therefore, the court required the prosecution to prove Crawford had recklessly disregarded the substantial risk that his repeated contacts would cause the victim serious emotional distress.

Supreme Court Ruling and Holding

The Colorado Supreme Court reversed the district court's order, concluding that the *Counterman recklessness mens rea requirement* does not apply to stalking charges based on repeated actions or contacts rather than the content of any communications.

The Court held:

- **No First Amendment Trigger:** Stalking charges not rooted in the specific content of communications do not invoke First Amendment protections.

- **Conduct vs. Content:** The First Amendment's protections, and thus the *Counterman recklessness requirement*, arise from the content-based nature of "true threats" and do not extend to content-neutral conduct such as repeated, unwelcome contacts. **Justice Melissa Hart** emphasized that "an **important distinction between prosecuting the frequency of contacts and the content of contacts**; any evidence proving that alleged criminal contacts occurred does not automatically create First Amendment protections for such contacts."

- **Jury Focus:** The First Amendment is not violated if a jury hears about the content of communications, as long as they are **instructed** to base a conviction solely on the fact and frequency of the contacts, and not the content itself. In other words, evidence of communication content is permissible if it only serves to prove the repeated actions that constitute the stalking offense.

Legal Implications for Stalking Charges

The ruling clarifies how ***Crawford* and *Counterman*** standards apply. By limiting the ***Counterman*** standard to instances where the stalking charge centers on the threatening content of the communication (a true threat), the Colorado Supreme Court preserved the **enforceability** of the state's stalking statute against repetitive, conduct-based offenses—affirming that the First Amendment is not implicated in content-neutral, conduct-based stalking.

This decision prevents a scenario in which stalking cases involving any form of communication (text, email, call) would require proof of reckless mens rea—a burden the Court warned would make it "**nearly impossible** to introduce any evidence for any crime whenever a defendant's communications were needed to prove an element of the crime." Crawford resolves a point of contention that had arisen in lower courts following *Counterman*, clarifying that, for the **majority of stalking prosecutions, the focus remains on the objective conduct**—repeatedly following, approaching, contacting, or surveilling—**and the resulting serious emotional distress caused to a reasonable person**.

Victim Safety Considerations

The Court strongly affirmed the legislature's intent to address the harm caused by repeated, content-neutral stalking behavior. The General Assembly recognized that the crime of stalking, characterized by "highly inappropriate intensity, persistence, and possessiveness," severely intrudes on a victim's "personal privacy and autonomy" and creates "great stress and fear," **even when lacking express threats**.

People v. Crawford reinforces the legal tool available to prosecutors to hold offenders accountable for patterns of intrusive and emotionally damaging conduct. By separating the **fact of contact from the content of speech**, the ruling prioritizes the **victim's right to be free from persistent, unwanted attention**, recognizing that the sheer repetition and unwelcome nature of the contacts can constitute the crime. The office of **Attorney General Phil Weiser**, who personally argued the *Counterman case* to the U.S. Supreme Court, urged the state's justices to adopt this view, stating, "Surveilling, following, and approaching a victim are particularly invasive acts that do not implicate speech. This is true even if stalkers don't say anything threatening — or even don't say anything at all."

Impact on Domestic Violence Offender Treatment

The ruling directly affects how the criminal legal system processes stalking cases, many of which are associated with domestic violence, given that stalking is one of the complex array of behaviors constituting intimate partner violence. These include:

- **Referrals for Domestic Violence Offender Treatment:** By curtailing the expansion of the Counterman standard, the Court ensures that stalking cases under 18-3-602(1)(c), C.R.S.—particularly those involving a repeated course of non-threatening but unwelcome conduct—can be prosecuted.

- **Prosecution and Treatment Eligibility:** Under a broader interpretation of *Counterman*, these cases might have faced dismissal or procedural barriers, especially when ordered to treatment where stalking behaviors could be minimized or denied under claims of First Amendment protection. This clarification is critical for cases referred to **DVOMB** Approved Providers for domestic violence offender treatment.

- **Focus on Objective Conduct:** The ruling maintains a focus on the offender's objective conduct (e.g., repeated contacts, approaches, or surveillance) rather than requiring proof of the offender's subjective intent regarding the emotional impact of their non-threatening communications. By focusing on the objective conduct that causes harm, courts can refer offenders to treatment programs targeting their high-risk, high-need profile to target future domestic violence recidivism risk.

Section 3: Milestones and Achievements

Overview of FY 2025 Accomplishments

During **FY 2025**, the **DVOMB** achieved significant milestones, successfully **meeting all three reauthorization mandates under HB 22-1210**, including the full operation of its data collection plan and conducting Standards Compliance Reviews (SCRs) on **11.4%** of active providers. Operational rigor included the Application Review Committee (ARC) reviewing **67 provider applications** with a **98.5% approval rate**, and managing **17 new complaints** while taking action, including the **permanent removal of one provider**, resulting from a prior-year founded complaint. The Board advanced major policy and practice initiatives by approving **nine significant revisions** to the *Standards and Guidelines* and successfully completing a statewide pilot of the revised risk assessment tool, the Domestic Violence Risk Need Assessment Revised (**DVRNA-R), now rebranded as Colorado Assessment Scale for Coercion and Abuse Desistance (CASCADE)**. Workforce development efforts, including the launch of **Phase Three of the recruitment strategy** and the **expansion of the provider pipeline to 42 Associate Level Candidates**, were sustained alongside a strong focus on **Individually Responsive Care (IRC)** principles. Finally, outreach and training remained a cornerstone, with **26 events** and the ODVSOM Annual Conference delivered, collectively reaching **over 1,100 attendees**.

Update on Implementation of Reauthorization Requirements

The latest **Sunset Review** by the **Colorado Department of Regulatory Agencies occurred in 2022**, resulting in the reauthorization of the **DVOMB** for five years, until **2027**. House Bill (HB) 22-1210 established three core requirements for this reauthorization, all of which the **DVOMB** has met or exceeded, as shown in **Table 5**.

Table 5. HB 22-1210 Reauthorization Requirements Compliance Summary.

HB 22-1210 Reauthorization Requirement	DVOMB Implementation Status
Develop and implement a data collection plan requiring Approved Providers to begin data collection no later than January 1, 2023.	**Met:** Plan approved and operational.
Perform compliance reviews on at least 10% of Approved Providers every two years, beginning no later than July 1, 2023.	**Met:** Reviews initiated on at least 10% of providers. Administrative policies are developed, embedded in *Standards and Guidelines*, and actively administered by the ARC.
Prepare and present an annual written report to the House and Senate Judiciary Committees on or before January 31st each year, beginning January 31, 2023.	**Met:** The 2026 report is the fourth consecutive report submitted.

Data Collection Plan and Implementation

The **DVOMB** approved its comprehensive data collection plan in **2022**, and it was implemented precisely on schedule on **January 1, 2023**. The data collection system completed its second full year of operation, providing the source for the client services and characteristics summary presented in Section One.

The **DVOMB** facilitated provider compliance by offering two submission platforms:

- **Provider Data Management System (PDMS):** An internal platform, established and maintained by the Colorado Department of Public Safety (CDPS) and provided free of charge to Approved Providers.

- **ReliaTrax:** A widely-used, privately-operated health record system subscribed to by many Approved Providers. This option is offered to minimize duplicate data entry and reduce administrative burden for providers.

The combined approach of utilizing the in-house PDMS and integrating with ReliaTrax is effective. Notably, ReliaTrax has been a **cooperative partner** in other **DVOMB** data collection projects (i.e., DVRNA-R pilot project). This data collection project has yielded a substantial amount of client-level data, **providing significantly greater insight** into client factors and treatment outcomes than was previously available. This robust data platform offers an excellent foundation for examining treatment effectiveness and measuring the impact of changes to **policy and practices**.

Standards Compliance Reviews (SCRs)

The **DVOMB's ARC** is responsible for administering the SCRs. The policies and practices for these reviews are fully developed and formally documented in the *Standards and Guidelines* Appendix D: Administrative Policies (VI)(B).

The **ARC** has met the statutory requirement to initiate **SCRs** on at least 10% of Approved Providers every two years, starting on or before July 1, 2023.

Key SCR policies and practices are:

- **Review Triggers:** Reviews may be conducted voluntarily, randomly, or for cause.

- **Exemption Policy:** Upon successful completion of an **SCR** (including any required Compliance Action Plan), an Approved Provider is exempt from being subject to a randomized SCR for a period of six years from the date the SCR is closed by the ARC. Approved Providers may still be subject to a For Cause SCR at any time.

- **System Integration:** The **SCR** process is being fully integrated into the provider data record of the **DVOMB** Provider Data Management System (PDMS) to ensure seamless tracking and management.

Annual Legislative Reporting

The **DVOMB** has consistently met its annual reporting obligation. The 2026 **DVOMB** Annual Legislative Report is the **fourth consecutive report** provided to the House of Representatives Judiciary Committee and the Senate Judiciary Committee. This report addresses all criteria stipulated in HB 22-1210 and highlights the **DVOMB's** work. Reports are readily accessible to the public through the DVOMB website.

The CASCADE Pilot Project: Revision of the DVRNA

In FY 2025, the **DVOMB** advanced its work on the **revision to the DVRNA** through a statewide **pilot project**. The DVRNA is required for all domestic violence offender assessments an**d determines treatment placement level**. Development of a revised tool was initiated in response to several critical factors:

- **Validation Study Findings:** A 2023 study confirmed that DVRNA placement levels had predictive validity but highlighted the need to strengthen the tool's overall predictive accuracy and structure. A summary of this study is reported in the **2024 DVOMB Annual Report**.

- **Standards Alignment:** The revision ensured consistency with the **2024 Treatment Competency Revisions** in the *Standards and Guidelines* and incorporated evolving best practices in actuarial risk assessment and domestic violence intervention.

- **Differentiated Risk:** The DVRNA relies heavily on static factors, often clustering clients in the high-intensity category, underscoring the need for a tool that better assesses dynamic and static risk and differentiates risk levels.

Rebranded as the **Colorado Assessment Scale for Coercion and Abuse Desistance (CASCADE)**, the revised assessment instrument incorporates an expanded set of dynamic risk factors that reflect criminogenic needs and individual circumstances that contribute to risk but are amenable to change. The instrument is structured to clearly distinguish between **static measures (12 items) and dynamic measures (21 items)**, in contrast to the DVRNA, which combines these domains into a single scale.The CASCADE also **aligns with the treatment competencies** outlined in the *Standards and Guidelines*, ensuring that assessment results directly inform treatment planning and progress monitoring. In addition, treatment intensity classifications have been expanded from three levels to **five levels (Levels 2-5)**, reflecting both the minimum number of required treatment plan reviews and the need for increased clinical contact beyond group sessions.

Pilot Outcomes

The FY 2025 pilot tested the CASCADE's content and face validity, refined training and supporting materials, and gathered implementation feedback. Key outcomes included:

- **Participation:** Collaboration with more than **60 Approved Providers and diverse judicial partners**, notably the State Court Administrator's Office, probation departments in the 4th, 6th, 7th, and 10th districts, and the 17th District Attorney Diversion Program. A core group of providers contributed data throughout the project.

- **Submissions:** 187 CASCADE assessments completed, with 150 **full scorings** analyzed.
- **Risk Distribution:** The revised Composite Risk Matrix in the CASCADE produced a broader spread across risk and treatment intensity levels, with 21% of individuals scoring in the Highest Risk category, 14% in the Moderate-High Risk category, 26% in the Moderate-Low Risk category, and 38% in the Low Risk category.
- **Subscale Performance:** The dynamic subscale effectively differentiated scores across a range of risk, while the static subscale appeared sound but skewed toward lower totals.
- **Feedback:** Stakeholder feedback was **overwhelmingly positive**. Monthly coaching sessions and the final survey provided ample opportunities for input, with responses reaching saturation and little negative commentary. Strengths cited included the separation of static and dynamic factors, expanded placement levels, and the ability to capture change over time.
- **Considerations:** Some challenges were noted concerning the additional time for scoring (although this eased with familiarity), the complexity of rescoring dynamic items, and concerns that critical factors from the DVRNA—such as nonfatal strangulation and weapon threats—were not weighted more heavily. These concerns are being examined in the next steps phase to **assess whether further adjustments are warranted**.

Next Steps

The CASCADE pilot project has now entered the Refinement and Analysis phase, which will include:

- **Tool Refinement:** Psychometric evaluation, classification analysis, and revisions to the manual, scoring guidance, and supporting materials.
- **Infrastructure Development:** Expansion of training curricula and creation of digital tools and technical assistance resources.
- **Statewide Rollout:** A phased implementation beginning in FY 2027, supported by coordinated communication and partner readiness efforts.

The **DVOMB** adopted the name **Colorado Assessment Scale for Coercion and Abuse Desistance (CASCADE)** to reflect the scope of the revision, emphasizing the instruments shift to a more dynamic, change-focused approach to assessment and treatment planning that supports desistance, and survivor safety.

Provider Recruitment Strategy

To address the need for p**rovider workforce sustainability and responsiveness** within the **DVOMB** and SOMB, the **ODVSOM** launched a multiphase recruitment project in **FY 2022** in partnership with Orange Circle Consulting (**Orange Circle**). This initiative was prompted by a steady decline in approved provider numbers, raising concerns about the l**ong-term stability of the workforce** and its capacity to ensure comprehensive client care. The project supports the priorities of both Boards by pursuing two key goals: (i) building a sustainable pipeline of providers and (ii) recruiting individuals with diverse backgrounds and experiences to better reflect and respond to the needs of clients and communities.

Phase One: Research and Insights (FY 2022). The project's first phase focused on **formative research** with potential recruits and current stakeholders. Findings, summarized in the **DVOMB 2023 Annual Legislative Report**, guided the development of inclusive recruitment strategies and resources designed to reach a broad pool of candidates and attract providers whose backgrounds reflect the client populations served.

Phase Two: Outreach Strategy Development (FY 2024). Launched in FY 2024, the second phase centered on developing **targeted outreach strategies**. Orange Circle tested messaging that highlighted the missions of the **DVOMB** and **SOMB**, their role in public safety, and the meaningful impact of provider work with individuals who perpetrate domestic violence and sexual violence. Input from three focus groups with key audiences informed the design of tailored recruitment strategies.

Phase Three: Asset Development and Testing (FY 2025). Building on prior research and strategy development, FY 2025 focused on **producing and piloting recruitment tools**:

- **Provider Video:** Developed with current Approved Providers to showcase clinical work and highlight the benefits of becoming a provider.
- **Customizable Slide Deck:** Designed to promote the work of both Boards and encourage interest in the treatment field.
- **Field Testing:** Both tools were piloted by Board members and ODVSOM staff in graduate-level human services courses, demonstrating effectiveness in academic settings.
- **Supplemental Video:** Featuring diverse providers sharing their experiences, further enriching the recruitment toolkit.

Next Steps: The final phase will emphasize **statewide dissemination** of recruitment resources and integration into existing presentations by **DVOMB** and **SOMB** staff. These tools will be implemented in **collaboration with university programs** in social work, clinical psychology, and mental health to strengthen the provider pipeline. They will also be leveraged through professional networks, conferences, and other opportunities to encourage licensed professionals to consider careers in the rehabilitation and management of individuals under the purview of the **DVOMB** or **SOMB**.

Efforts to Enhance Individually Responsive Care

The **DVOMB** is committed to ensuring that its *Standards and Guidelines* and professional development opportunities promote practices that are relevant and responsive to the **unique needs and backgrounds of all individuals**. This commitment is reflected in the reframing of our collective efforts under the term **Individually Responsive Care (IRC)**.

Individually Responsive Care Committee Work

In FY 2025, the **Individually Responsive Care (IRC) Committe**e (formerly the Diversity, Equity, Inclusion, and Belonging Committee) spearheaded several key initiatives to ensure an IRC lens across the Board's functions:

- **Infusing IRC Across the Committees:** Committee members were **strategically appointed** to other **DVOMB** committees to "infuse" an **intentional IRC perspective** into all proceedings. In contrast to meeting monthly in the IRC committee, members opted to join other committees and meet as the IRC quarterly to ensure regular Board work included discussions on cultural humility, awareness of privilege, and the impact of the work on historically marginalized communities, providers, advocates, and supervising officers.

- ***Standards and Guidelines* Update:** A major focus of work was on beginning a comprehensive review of Appendix B of the *Standards and Guidelines*, which guides working with **specific offender populations**. This work aims to update language, integrate evidence-based research on unique populations (namely, female and LGBTQ+ clients), and ensure policies reflect contemporary best practices in treating diverse individuals.

- **Accessibility and Policy Review:** The Committee **reviewed updates** to the *Standards and Guidelines* to ensure an IRC lens was applied. They specifically advised on teletherapy revisions, noting the potential benefit of teletherapy to connect clients to native language speakers. They also confirmed that the **DVOMB** website and provider search and standards list comply with accessibility standards for users relying on digital readers.

Ongoing Board-Wide Efforts

Beyond the Committee's work, the DVOMB sustained several ongoing strategies to **enhance competency** and ensure standards support equitable treatment outcomes, as shown in **Table 6**.

Table 6. Ongoing DVOMB Strategies to Enhance Individually Responsive Care.

Area of Effort	FY 2025 Activities
Training and Professional Development	Delivered targeted training on cultural competency and individualized care, including a conference presentation on privilege and cultural humility. Required all annual conference presenters to address diversity and inclusivity.
Standards Revisions	Applied an **Individually Responsive Care (IRC) framework** to all policy updates, ensuring revisions address diverse client needs (e.g., cultural/ethnic backgrounds, gender, disabilities, cognitive differences).
Policy and Accountability	Maintained the ODVSOM Training Conduct Policy, outlining expectations for participant conduct and staff procedures for responding to inappropriate comments regarding identity or culture.
Recruitment and Representation	Continued proactive efforts to recruit **diverse members** to the DVOMB and its committees, ensuring broad representation from providers and key stakeholder groups.
Inclusivity & Awareness	Promoted inclusivity by recognizing cultural heritage months and key awareness initiatives through integrated guest speakers and focused discussions.
Resource Accessibility	Ensured DVOMB digital resources (website, provider tools) comply with **digital accessibility requirements** and advanced strategies to improve accessibility of all communications and materials.

Community and Stakeholder Outreach

Traveling Board Meetings

The **DVOMB** continues its commitment to **statewide engagement** through its annual traveling board meeting program. These meetings are designed to connect directly with communities across Colorado, strengthen local partnerships, and ensure Board policies are informed by regional perspectives.

In October 2024, the **DVOMB** held its traveling meeting in **Alamosa, Alamosa County**. Leading up to the event, **DVOMB** staff conducted targeted outreach to Approved Providers and stakeholders in the host and surrounding counties to encourage strong attendance and participation.

While essential board business is addressed, traveling meetings place a key emphasis on:

- Updating **local stakeholders** on recent **DVOMB** activities and policy developments.
- **Hearing directly** about local challenges, concerns, and initiatives.
- **Gathering insights** to inform committee work, policy revisions, and resource development.

Key Outcomes from the Alamosa Meeting: The Alamosa meeting provided an important forum for information exchange and collaboration:

- **Board Updates:** Staff and members shared progress on priority initiatives, including revisions to core treatment competencies, the DVRNA-R pilot program, Section 7.0 (Victim Advocacy) revisions, emerging research, and provider recruitment strategies.
- **Local Input:** The Board heard directly from key partners, including the 12th Judicial District Attorney, domestic violence treatment providers, and Probation representatives.

The **DVOMB** remains committed to holding one traveling board meeting each calendar year. Agencies or individuals interested in hosting a future meeting are encouraged to **submit a request** through the **DVOMB** website or by contacting **DVOMB** staff.

Round Tables (Hiatus FY 2025)

DVOMB staff convene **roundtable discussions to strengthen collaboration and feedback** between the Board and communities across Colorado. These forums are typically organized at the request of community members, in response to emerging issues of concern, or as a way to foster outreach and build a community of practice among providers and stakeholders. Open to Approved Providers, community partners, and the public, roundtables create space to address local challenges, share strategies, and explore opportunities to improve domestic violence response and prevention.

*Note: Due to the resource-intensive DVRNA-R pilot project the Roundtable program was suspended for FY 2025. This temporary hiatus allowed the team to successfully meet pilot commitments, including developing and delivering extensive training and coaching. The **DVOMB** plans to resume this valuable community outreach in the next fiscal year. Interested communities can submit requests via the **DVOMB** website.*

Domestic Violence Taskforce Development

The **DVOMB** supports local efforts to establish **cross-agency domestic violence task forces** when requested by counties or community stakeholders. A domestic violence task force **strengthens local coordination and response** by bringing together agencies such as probation, treatment providers, victim advocacy, and law enforcement. Where requested, the **DVOMB Program Coordinator or Implementation Specialist** can provide frameworks, outline essential components, and offer technical assistance to aid in task force development. In FY 2025, **DVOMB** staff provided technical assistance to members of the **Denver City Task Force** and **Montrose County Task Force**. In addition, **DVOMB** staff provided general training with Adams County Social Services.

Applications for Placement on DVOMB Approved Provider List

Due to the **seriousness and sensitive nature of domestic violence**, professionals providing evaluation and treatment services must demonstrate specialized training, competencies, and expertise in offender dynamics and victim safety. Pursuant to **§ 16−11.8−104, C.R.S.**, **only DVOMB Approved Providers** may conduct post-conviction evaluations and treatment services in Colorado.

Provider Qualification Framework

The requirements for provider approval are formally outlined in the *Standards and Guidelines, Section 9.0 (Provider Qualifications)*. The approval structure supports **career progression** through **three practice levels: Associate Level Provider Candidate, Associate Level Provider, and Full Operating Level Provider**. Specialized listings are also available for roles such as **Domestic Violence Clinical Supervisor (DVCS)** and working with **Specific Offender Populations** (e.g., female or LGBT clients).

Placement on the **Approved Provider List** confirms an applicant has met the requisite education and experience and that their proposed services align with the *Standards and Guidelines*. It is important to note that this approval does not constitute a professional license or certification; nor does it imply service uniformity or guarantee referrals from criminal justice agencies.

A core element of the approval process is the **Competency-Based Model (CBM)**, adopted in **2016**. The CBM evaluates providers across key domains, including the integration of *Standards and Guidelines*, understanding offender dynamics, intervention skills, victim safety considerations, and treatment planning. Applicants at the **Candidate** and **Associate levels** must practice under the structured guidance of a **DVCS**, who assesses competencies and endorses advancement only when the applicant demonstrates proficiency and ethical readiness for the next listing level.

FY 2025 Application Review Committee (ARC) Outcomes

The **ARC** manages the primary mechanism by which providers enter, advance, or maintain their approved status. The ARC process is deliberately collaborative, supporting applicants in submitting complete materials, addressing questions, and resolving concerns while consistently upholding the *Standards and Guidelines*. In FY 2025, the ARC reviewed **67 applications**, resulting in the approval of **66 (98.5%)**, as shown in **Table 7**. This consistently **high rate** reflects the efficiency and collaborative nature of the process.

Table 7: DVOMB Count of Applications, FY 2025.

Application Type	Number Submitted	Number Approved	Number Pending[a]
App 1 - Initial Listing as Candidate[b]	36	36	0
App 2 – Listing or Level Upgrade	28	28	0
App 3 - Renewal[c]	3	2	1
Total	67	66	1

Source: DVOMB Provider Data Management System.

a. Pending refers to applications with missing information or pending staff/ARC review.
b. This was formally listed as Entry Level or Provisional Status before FY 2024.
c. Renewal applications were minimal, as they occur on an alternating-year schedule.

The three types of applications are:

- **App 1: Initial Applications (36 total)**. Requests for Associate Level Candidacy, which allow providers to begin practicing under supervision while completing the training required for advancement.

- **App 2: Status Upgrade Applications (28 total)**. Requests to advance to a higher practice level (e.g., Associate to Full Operating Level) or to add a specialization (e.g., working with specific offender populations).

- **App 3: Renewal Applications (3 total)**. Requests to continue at the current listing status. Renewal applications were minimal, as renewals occur on an alternating-year schedule.

The **28 status upgrade applications (App 2)** received effectively highlight the ongoing **professional development** within the provider community. Of these, **19 involved Level Advancements**, demonstrating career progression across various stages: 10 candidates moved from Associate Candidate to Associate Level, 3 advanced from Associate Level to Full Operating Level, 5 progressed from Full Operating Level to Clinical Supervisor Apprentice, and 2 completed their final step, advancing from Clinical Supervisor Apprentice to Clinical Supervisor. The remaining **9 applications involved Specialty Listings**, with 6 providers requesting the **Female Clients** listing and 3 requesting the **LGBT Clients** listing; notably, one of these applications sought both specialty listings simultaneously.

Current Availability of DVOMB Approved Providers

In FY 2025, the **DVOMB** had **181 active providers** and **14 providers not currently practicing** in Colorado as shown in **Table 8.** The Associate Level Candidate designation was introduced in FY 2024 to replace Trainee Status, and the Clinical Supervisor Apprentice category was introduced in FY 2023. Clinical Supervisor Apprentices and Clinical Supervisors remain approved to provide direct client services. In FY 2025, there was **growth of the Associate Level Candidate category, which expanded to 41 providers, strengthening the provider pipeline. Figure 5** shows the number of Approved Providers by county; Approved Providers located in all 23 judicial districts in the state.

In FY 2025, **140 providers were approved for female clients** and **60 for LGBT+ clients,** with these listings requiring additional training and oversight. Providers may also **self-identify** languages, therapeutic modalities, and areas of specialization on their **DVOMB** listing to better communicate their services; however, these are not formally overseen by the **DVOMB**. In FY 2025, **35 providers reported Spanish-language services,** with additional languages including Portuguese, Vietnamese, Bengali, French, and German. Other self-identified areas included substance use treatment, trauma-focused interventions, anger management, specialized treatment models, and services for young adults and military/veterans.

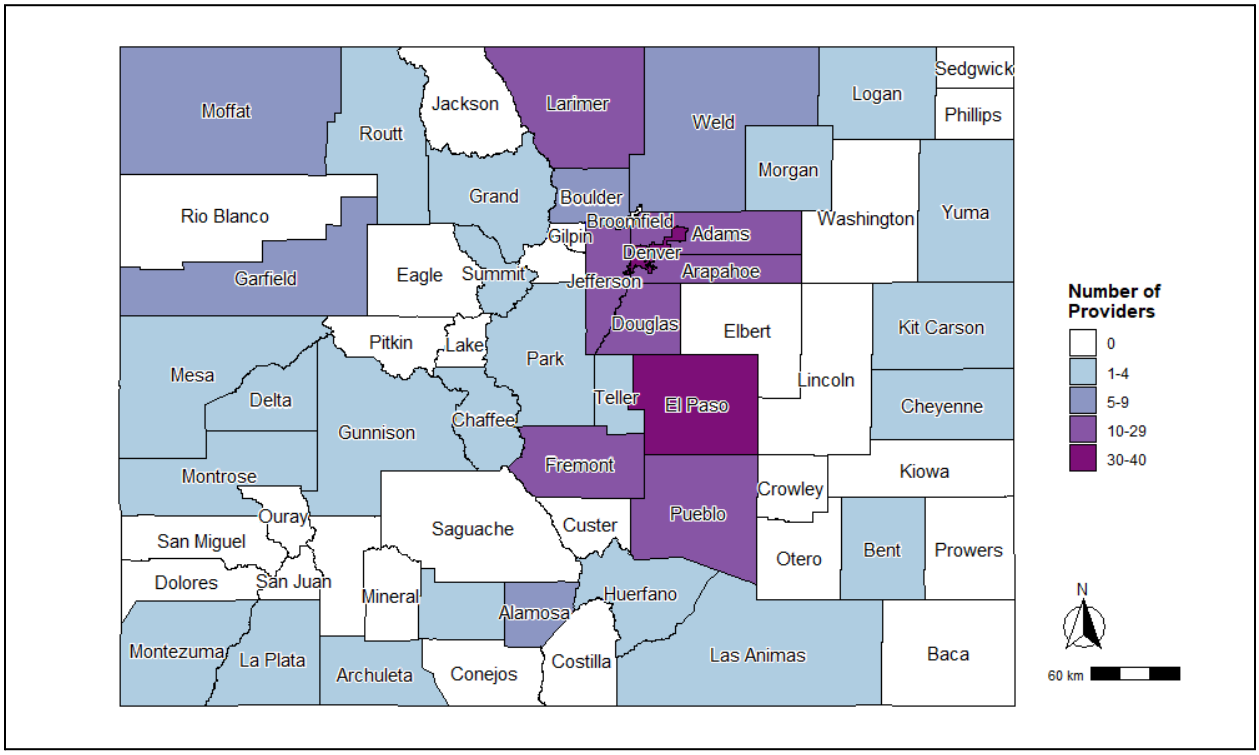
Table 8: Number of Approved Providers in Colorado Over the Last Five Fiscal Years.

Level	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Associate Level Candidate[a]	-	-	-	24	42
Associate	35	36	39	40	45
Full Operating	94	90	82	71	57
Clinical Supervisor Apprentice[b]	-	-	2	6	10
Clinical Supervisor	37	31	29	30	27
Subtotal	**168**	**159**	**153**	**171**	**181**
Not Currently Practicing[c]	23	16	32	21	14
Grand Total	**191**	**175**	**185**	**192**	**195**

Source: DVOMB Provider Data Management System.

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 retains the providers' listing status when not providing direct services.

Figure 5: Number of DVOMB Approved Providers by County, FY 2025. Data Table Appendix A. Source: DVOMB PDMS.



Complaints Received Against Providers

The *Standards and Guidelines, Appendix A: Administrative Policies, Section VI(C)*, sets the formal process for addressing concerns about Approved Providers. **Complaints may be submitted by various stakeholders** (victims, offenders, probation, community members, etc.) if a provider's conduct is believed to violate the *Standards and Guidelines* or professional license requirements. The **DVOMB** has statutory authority (**§16-11.8-103(4)(a)(III)(D), C.R.S.**) to review complaints through the ARC and must forward them to DORA. The **DVOMB's** authority is limited to complaints concerning individuals who were Approved Providers at the time of the alleged violation. All complaints outcomes include a structured process for **reconsideration and appeal**.

Upon review, complaints may be categorized as follows:

- **Dismissed**: A complaint is **dismissed** if it falls **outside the Board's jurisdiction or does not substantially allege a standards violation**. For example, a complaint filed against an individual who is not a **DVOMB** Approved Provider, or one related to billing practices rather than a standards violation, would be dismissed.

- **Unfounded**: A complaint is deemed **unfounded** if it is **not supported by evidence**, and no violation is recorded. For example, a complaint alleging that a provider failed to disclose sharing concerns with the supervising agent may be unfounded if the signed treatment contract clearly documents this requirement.

- **Founded**: A complaint is **founded** when **evidence supports the allegation, resulting in formal action and a recorded violation**. For example, a provider who consistently fails to complete required treatment plan reviews is in clear violation of standards, leading to corrective action and a recorded violation.

As shown in **Table 9**, in FY 2025, the **DVOMB** received 17 complaints against 12 approved providers. By the end of FY 2025, 4 were dismissed, 6 were unfounded, and 7 remained pending. Additionally, resolution efforts continued on 7 complaints against 4 providers carried over from FY 2024.

Table 9: Provider Complaints and Outcomes, FY 2025.

Outcome	Complaints Received in FY 2025	Complaints from FY 2024 Resolved in FY 2025[a]
Dismissed	4	3
Unfounded	6	1
Founded	0	1
Pending	7	2[b]
Total	**17**	**7**

Source: **DVOMB** Provider Data Management System.

a. These complaints were received by the **DVOMB** in FY 2024 but were not resolved until FY 2025. This total does not include complaints received and resolved in FY 2024.

b. These pending complaints remain unresolved due to the provider's removal from the Approved Provider List.

Founded Complaint Outcome: The ARC determined that the provider had violated Guiding Principle 3.17, Section 9.0 (Provider Qualifications), Standard 5.03 IV, and Section 6.0 of the **DVOMB** *Standards and Guidelines*. In light of the seriousness of these violations, ARC **removed the provider from the Approved Provider List and rendered them ineligible for future reapplications.**

Standards Compliance Reviews (SCRs)

SCRs are a formal process executed by the ARC to verify Approved Providers' adherence to the *Standards and Guidelines*. Pursuant to §16-11.8-103(4)(a)(III)(D), C.R.S., the ARC is required to perform compliance reviews on at least ten percent of treatment providers every two years. SCRs can be initiated in three ways:

- **Voluntarily**: A provider self-selects for review.
- **Randomly**: Periodic, randomly chosen, checks of compliance.[12]
- **For Cause**: Initiated when sufficient information or a complaint alleges non-compliance in accordance with Appendix A of the *Standards and Guidelines*.

[12] Providers who elect a voluntary SCR or are randomly selected, and found to comply with the *Standards and Guidelines*, are exempt from another random selection for the next six years.

The intensity of SCRs falls into one of three levels, commensurate with the direction given by the ARC:

- **Level 1, Implementation Verification**: Evaluates administrative, training, or MTT consultation.
- **Level 2, Work Product Review**: Adds the evaluation of written documents, such as offender evaluation summary reports, treatment plans, and discharge summaries.
- **Level 3, Site Visit and File Review**: Adds a comprehensive audit that includes Level 2 requirements plus a review of client files and observation of services.

Upon review, the ARC can reach one of four main determinations, which are communicated to the Approved Provider in writing within 21 days. The outcomes are:

- **Successful Compliance**: Approval for continued placement with no further action required.
- **Innovative Practice Identified**: A best or innovative practice identified, potentially leading to an increase in the provider's practice level.
- **Violations Found**: The provider is typically offered a Compliance Action Plan (CAP) to systemically resolve the issues. The practice level may be retained or temporarily reduced while the CAP is in effect.[13]
- **Administrative Action**: Failure to comply with a CAP, or inability to resolve the founded violations, can result in further administrative action, including recommendation that a formal complaint be opened by the **DVOMB** and forwarded to the Department of Regulatory Agencies (DORA).

As detailed in **Table 10**, the ARC initiated a total of **20 SCRs over the two years**, with 10 initiated in FY 2024 and 10 in FY 2025. This collective effort monitored **11.4%** of all active listed providers, inclusive of Associate Level Candidates, thereby successfully meeting the statutory requirement to review at least 10% of active providers every two years. Sixteen SCRs were conducted at a level 2 intensity and four at level 3 intensity.

Table 10: Standards Compliance Reviews Initiated, FY 2024 and FY 2025.

SCR Type	FY 2024	FY 2025
Voluntary	4	2
Random	3	6
For Cause	3	2
Total	**10**	**10**

Source: **DVOMB** ARC Records.

[13] Resolved violations from Voluntary and Random SCRs remain confidential; For Cause SCR violations are public record.

As shown in **Table 11**, approximately **33%** of SCRs resulted in a **CAP**, a structured mechanism for providers to correct identified violations. Pursuant to **§ 16-11.8-103(4)(a)(III)(D), C.R.S.**, and *Section VI of the Administrative Policies*, CAPs outline specific required actions, documentation, and timeframes to achieve systemic resolution of deficiencies. Common violations addressed include omissions in **evaluation reports, treatment plans, discharge summaries, teletherapy agreements**, and inadequate **clinical rationale documentation**. CAPs are completed under the direct oversight and technical support of a **DVCS**, who formally attests that improvements have been implemented. Providers retain their approved status upon successful CAP completion, while non-compliance may lead to administrative action, including reduction or removal from the Approved Provider List.

Table 11: Standards Compliance Review Outcomes, FY 2024 and FY 2025.

SCR Type	FY 2024	FY 2025
Successful Compliance	5	1
Innovative Practice Identified	0	0
Violation Found: Compliance Action Plan (CAP)	3	2
Administrative Action	0	0
Deferred[a]	2	2
Pending[b]	0	2
Closed[c]	0	1
Total	**10**	**10**

Source: **DVOMB** Provider Data Management System.

a. SCRs are deferred when the provider moves to Not Currently Practicing status or when, due to health or other situational issues, the SCR cannot proceed at the time. The SCR is scheduled to occur should the provider return to active practice.
b. SCRs are pending if they are still in process at the end of the fiscal year.
c. The SCR was closed as the provider was retiring.

The staff, in collaboration with the **ARC**, will review the **SCR policy and processes** following the framework's initial implementation phase (developed in FY 2024, fully implemented in FY 2025). The upcoming cycle will assess the model's practical operation, focusing on the **adequacy of Level 1 reviews** and evaluating the **decision rules** for escalating review intensity (e.g., Level 1 to 2, or 2 to 3) to ensure alignment with program needs.

ODVSOM Shared Services Model

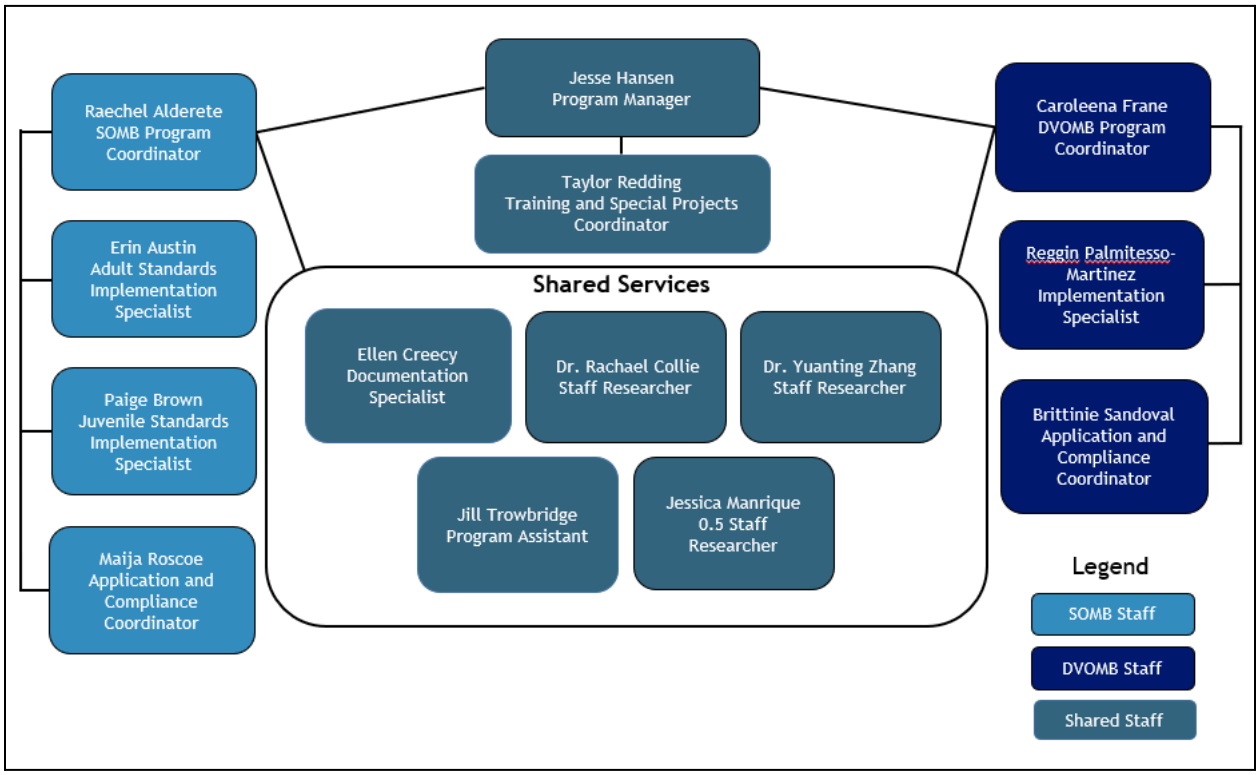
The ODVSOM provides **unified**, **professional staff support** for both the **DVOMB** and the **SOMB**. Staff members, **many holding advanced degrees**, offer specialized expertise crucial for statewide implementation of evidence-based policy, training, and oversight. Formed in **2016** by merging previously separate staff teams, the office aimed to **reduce duplication and improve efficiency** while respecting each Board's distinct legal authority. The model was further refined and implemented in **2023** to address the growth in provider listings, the increasing complexity of the *Standards and Guidelines*, and additional legislative mandates.

The current **Shared Services Model** (see Figure 6) centralizes administrative, planning, and research functions while designating **specialized roles** to ensure accountability to both Boards. Each role leverages advanced professional expertise to enhance efficiency, oversight, and statewide impact:

- **Program Manager** provides executive-level leadership, integrating staff functions, coordinating strategic initiatives, and ensuring consistent and effective support for both Boards in meeting legislative and stakeholder expectations.
- **Program Coordinators** provide high-level administrative and strategic leadership for both Boards, maintaining a comprehensive view of operations, ensuring alignment with statutory mandates, and managing stakeholder engagement and Board processes.
- **Implementation Specialists** lead technical revisions to the *Standards and Guidelines*, staff Board committees, and deliver specialized technical assistance to multidisciplinary teams, ensuring fidelity to best practices.
- **Application and Compliance Coordinators** oversee provider application and renewal processes, support the ARC, and manage SCRs to uphold statewide accountability.
- **Training and Special Projects Coordinator** designs and administers professional development initiatives, including coordination of the statewide annual conference, and expands training opportunities for providers and stakeholders.
- **Researchers** manage provider databases, conduct research and special projects, complete literature reviews, and support working groups with analytical expertise. They also prepare legislative reports and provide evidence-informed analysis to guide policy and standards development.
- **Administrative Personnel** provide skilled operational support, streamlining record management, refining administrative processes, and ensuring efficient day-to-day functioning of the office.

This **highly qualified and role-specific staffing model** enables the **ODVSOM** to operate as a professional, research-informed, and responsive entity, equipped to support the full scope of both Boards' mandates.

Figure 6: The ODVSOM Shared Services Model and Organizational Chart, FY 2025. Data Table Appendix A.



Policy Updates

The **DVOMB** conducts much of its work through **standing and ad hoc committees** composed of Board members, staff, and invited stakeholders. All meetings are **open to the public** (online or hybrid) to maximize accessibility. Committees provide regular updates at monthly Board meetings and bring forward proposals for ***Standards and Guidelines* revisions**, policy briefs, resource development, and training initiatives. Their work is grounded in **current research and best practices**, with proposals supported by evidence and strategies for effective public and practitioner education. During FY 2025, the **DVOMB** staffed **six active, transparent committees** to fulfill its statutory responsibilities (**§ 16-11.8-103, C.R.S**). A summary of committee work and policy development for FY 2025 is provided in **Appendix B.** The committees were:

- Executive Committee
- Application Review Committee
- Individualized Responsive Care Committee
- Standards Revisions Committee
- Victim Advocacy Committee
- Training Committee (in collaboration with the Sex Offender Management Board)

Significant policy work conducted in FY 2025 included:

- **Section 9.0, 10.0, and Administrative Policies (Criminal History):** Revised in May 2025 with an implementation date of November 2025 to clarify requirements for provider qualifications and criminal history disclosures.
- **Section 5.06 and Appendix I (Teletherapy):** Approved in April 2025 and implemented in October 2025 to refine standards governing the use of teletherapy in offender treatment.
- **Section 6.0 (Treatment Contract and Confidentiality):** Revised in February 2025 and implemented in August 2025 to update requirements related to informed consent, confidentiality, and treatment contract language.
- **Appendix D (Language Interpretive Services):** Approved in January 2025, with implementation in July 2025 to provide an overview and guidance for working effectively with interpretive services.
- **Section 7.0 (Victim Advocacy):** Updated in August 2024 and implemented in February 2025 to strengthen requirements for Treatment Victim Advocates, including training expectations and alignment with confidentiality statutes.
- **Sections 9.01-9.04 and Administrative Policies:** Approved in August 2024 and implemented in February 2025 to further refine provider qualifications and related administrative processes.
- **Section 1.0 (Purview of the DVOMB):** Approved in May 2024 and implemented in November 2024 to clarify the statutory authority and scope of the Board.
- **Section 4.01 (Translation and Interpretive Services):** Approved in February 2024 and implemented in August 2024 to strengthen language access requirements.
- **Section 5.03 (Core Competencies):** Approved in January 2024 and implemented in July 2024 to reflect advances in research and best practices related to treatment competencies.
- **Purview Issues and Impact of HB 23-1178** on Reunification Proceedings in Civil Courts.

Ongoing Implementation

The implementation process ensures that Approved Providers understand and adhere to the *Standards and Guidelines* while supporting the effective functioning of the MTT. Implementation is supported through four key elements: **communication**, **training**, **resource development**, and **technical assistance**.

- **Communication**: The **DVOMB** distributes updates through email notices, a **quarterly newsletter**, announcements at meetings and events, and the **DVOMB website**, which houses the *Standards and Guidelines*, training information, and other resources.
- **Training**: Training opportunities include **core workshops** on the *Standards and Guidelines*, offender evaluation and treatment, and the DVRNA. In addition, the **DVOMB** offers bi-monthly **"lunch and learn"** sessions on practice issues, **advanced training seminars** delivered by subject-matter experts, and the **ODVSOM Annual Conference**.

- **Quick Guide Resources:** To support understanding, the **DVOMB** developed **one-page information sheets** on key aspects of its approach, including the **DVOMB** treatment model, treatment competencies, and MTTs. These concise reference tools are designed to be accessible and user-friendly for providers, stakeholders, and clients.
- **Support and Technical Assistance**: Providers have access to **bi-monthly technical assistance hours** and ongoing support from **DVOMB** staff for questions related to implementation and compliance.

The **DVOMB** continues to refine its implementation strategies to improve communication, expand training, and strengthen provider support statewide.

Training

In FY 2025, the **DVOMB** delivered **26 trainings** and hosted the **ODVSOM Annual Conference**, reaching over **1,060 attendees**. The ODVSOM Annual Conference served as a critical platform for collaboration, drawing over **500 stakeholders**. In addition, the **DVOMB** regularly included lunchtime presentations at its monthly Board meeting, accessible to the field and the public via in-person attendance, online streaming, and recorded archives. All recorded training and seminars are archived on the **DVOMB's training hub**, offering providers and stakeholders **on-demand access** to professional development resources.

Training events were **strategically designed to enhance the treatment and supervision** of individuals convicted of domestic violence offenses and address fundamental knowledge and evolving needs. The curriculum included required **foundational courses** (e.g., the DV 100 series) necessary for approved providers to maintain compliance with the *Standards and Guidelines*, as well as **specialized, higher-level topics** delivered to a broad audience of stakeholders. The latter category is flexible, with topics varying by year or being developed on request to address emergent issues in the field. In two instances, training was delivered beyond Colorado to share the state’s treatment approach with the wider domestic violence treatment field.

The FY 2025 curriculum included the following foundational and specialized topics:

- DV100 - **DVOMB** and Standards Overview
- DV101 – Domestic Violence Risk and Needs Assessment Training
- DV102 – DV Offender Evaluation Training
- DV103 – DV Offender Treatment Training
- DV200 - Community Roundtables (by request)
- DVRNA-R 2-day Training for Providers
- DVRNA and Multidisciplinary Treatment Team Practices for Probation Officers
- DVRNA and Multidisciplinary Treatment Team Practices for DHS Case Workers
- Domestic Violence Offenders and the Legal and Practical Aspects of Firearm Access

- The Use of Lethality Assessment and a Multidisciplinary Approach to Curb Intimate Partner Homicide
- What's New with Treatment Victim Advocates in the **DVOMB** 7.0 Standards
- Intimate Partner Violence: Awareness, Prevention, and Support
- Understanding the Difference Between Criminogenic Needs and Responsivity
- The LATTICES program for High-Risk Criminal Clients
- The Role of Data Collection
- Ending Violence Against Women
- Building Resiliency and Retention in Probation Officers Working with Gender-Based Violence and High-Intensity Caseloads
- Effective Approaches to Working with Difficult Gender-Based Violence Probation Clients

Summary

During FY 2025, the **DVOMB** achieved **significant milestones**, advancing domestic violence offender treatment and supervision across Colorado. The Board's achievements across its **core mandates** demonstrated **full compliance with reauthorization requirements**, advancements in provider oversight, and significant progress in risk assessment and recruitment efforts.

Reauthorization Compliance and Data Infrastructure

The **DVOMB** successfully met all three core requirements established by **House Bill (HB) 22-1210**, which reauthorized the Board until 2027:

- **Data Collection:** The **DVOMB's** comprehensive data collection plan was **fully operational** on schedule (January 1, 2023), completing its second full year. The system uses a combined approach of the internal **Provider Data Management System (PDMS)** and integration with the private system **ReliaTrax**, yielding a substantial amount of client-level data for deeper insights into client factors and treatment outcomes.
- **Compliance Reviews:** The Board **met the statutory requirement** to perform SCRs on **at least 10% of Approved Providers every two years**. The ARC conducted **20 SCRs** across FY 2024 and FY 2025, covering **11.4% of active providers**.
- **Annual Reporting:** The **DVOMB** is consistently meeting its annual reporting obligation to the Legislature.

Provider Management: Applications, Complaints, and Oversight

The **DVOMB** maintained oversight of its provider network while focusing on pipeline growth and quality assurance.

- **Provider Applications and Pipeline Growth:** The ARC reviewed **67 applications** in FY 2025, with a **98.5% approval rate (66 approved)**. The **Associate Level Candidate** category expanded to **42 providers**, demonstrating strong growth in the provider pipeline. The provider community includes **181 active providers** located across all 23 judicial districts. **Twenty-eight** applicants successfully advanced their practice level or added specializations (e.g., working with female clients (**140 approved**) and LGBT+ clients (**60 approved**)).

- **Provider Complaints and Conduct:** The **DVOMB** managed **17 new complaints** in FY 2025, in addition to 7 carried over from FY 2024. Of the prior-year complaints, **one was founded**, leading to the provider's **permanent removal from the Approved Provider List** due to serious violations of standards.

- **Standards Compliance Reviews (SCRs):** The SCR process resulted in a **CAP** for approximately **33% of finalized reviews** in FY 2024 and FY 2025. CAPs provide a structured way for providers to correct identified deficiencies (e.g., report omissions) under the guidance of a Domestic Violence Clinical Supervisor (DVCS).

Individually Responsive Care (IRC) and Workforce Development

The **DVOMB** has prioritized efforts to ensure its work is responsive to the unique needs of diverse clients and communities.

- **IRC Committee Work:** The IRC Committee worked to **infuse an intentional IRC perspective** across all Board activities, advising on policy updates, ensuring **digital accessibility** of materials, and beginning a comprehensive review of standards guiding work with specific populations (female and LGBTQ+ clients).

- **Recruitment Strategy:** The **ODVSOM Shared Services Model** launched Phase Three of its multi-year recruitment project in FY 2025, developing and piloting a **provider video, customizable slide deck, and supplemental video** to attract diverse professionals and strengthen the pipeline in collaboration with university programs.

- **Shared Services Model:** The **ODVSOM** continues to operate under its fully implemented Shared Services Model (merged with the SOMB), centralizing administrative, planning, and research functions with **role-specific staff** to enhance efficiency and provide specialized support.

Policy, Training, and Outreach

The **DVOMB** advanced critical policy revisions and maintained robust engagement with stakeholders.

- **Policy Updates:** Through its six active committees, the **DVOMB** completed **nine significant policy updates** in FY 2024–2025, strengthening requirements for provider qualifications, teletherapy, treatment contracts, Victim Advocates, and language interpretive services.

- **Training and Development:** The **DVOMB** delivered **26 trainings** and hosted the **ODVSOM Annual Conference**, reaching **over 1,100 attendees** and offering foundational courses (DV 100 series) and specialized topics (e.g., lethality assessment, firearm access).

- **Community Outreach:** The Board continued its commitment to engagement by holding its annual **traveling board meeting in Alamosa** (Alamosa County) to connect with local stakeholders and gather regional input.

- **CASCADE Pilot Project:** The **DVOMB** successfully completed the FY 2025 pilot of the revision to the DVRNA. The **DVOMB** rebranded the instrument to the **Colorado Assessment Scale for Coercion and Abuse Desistance (CASCADE)** to reflect the scope of the revision and greater emphasis on a more dynamic, change-focused approach to assessment and treatment planning that supports desistance, and survivor safety. The pilot included **over 60 Approved Providers** and partners, resulting in **187 assessments completed** (150 fully scored). The revised tool successfully produced a **broader spread of risk levels** and separates static and dynamic risk factors to better guide treatment planning and monitor client change over time. Statewide rollout is planned to begin in FY 2027.

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. Over the past 20 years, knowledge on domestic violence has evolved significantly, making the **periodic revision** of the *Standards and Guidelines* a key strategic priority. This process ensures the *Standards and Guidelines* reflect new research, evidence-based practices, and the foundational role of the **RNR model** in effective offender management.

For the upcoming fiscal year, the **DVOMB's strategic priorities** will focus on enhancing domestic violence offender treatment through refinement, evaluation, and renewed stakeholder engagement. A key milestone will be the **statewide implementation** of the revised DVRNA, renamed the **CASCADE**, which **modernizes and strengthens both risk assessment and treatment planning processes**. The **DVOMB** will also advance its provider recruitment strategy and conduct a review of its **SCR** policies and procedures following the first two years of implementation. In addition, the Board will e**xplore the feasibility of developing a clarification intervention**—recommended through its examination of restorative justice practices—to better meet victim needs and support offender accountability. The **DVOMB** will reinitiate **community roundtables** and continue supporting domestic violence task forces across the state to deepen partnerships and promote collaboration in advancing shared public safety goals. Finally, the DVOMB will focus its planning and reporting efforts on preparing for the **Sunset review by DORA in 2027**.

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Appendices

Appendix A. Data Tables

Table 12. Figure 1 Referral Sources, FY 2025 (Count 4,259)*.

Referral Source*	**Count**	Percent (%)
Probation	3,755	88%
Private Probation	216	5%
Community Corrections	107	3%
Parole	98	2%
Diversion	62	1%
Court	59	1%
Other	15	<1%
County DHS/DYS	11	<1%
Private Attorneys	4	<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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Table 13. Figure 2 Distribution of Treatment Levels, FY 2025 (Count 4,244).

Treatment Level	**Count**	Percent (%)
Level A	76	2%
Level B	1,123	26%
Level C	3,045	72%

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Table 14. Figure 3 Discharge Outcomes by Treatment Level, FY 2025 (Count 4,244).

Treatment Level A (Count 76)

Discharge Outcome	**Count**	Percent (%)
Completed Discharge	64	84%
Unsuccessful Discharge	5	7%
Administrative	7	9%

Treatment Level B (Count 1,123)

Discharge Outcome	**Count**	Percent (%)
Completed Discharge	821	73%
Unsuccessful Discharge	246	22%
Administrative	56	5%

Treatment Level C (Count 3,045)

Discharge Outcome	**Count**	Percent (%)
Completed Discharge	1,594	52%
Unsuccessful Discharge	1,234	41%
Administrative	217	7%

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Table 15. Figure 4 Treatment Length by Treatment Level, FY 2025 (Count 4,243).

Treatment Level A (Count 76)

Discharge Type	Median Length of Treatment (Months)
Completed	6.0
Unsuccessful	4.1
Administrative	1.8

Treatment Level B (Count 1,123)

Discharge Type	Median Length of Treatment (Months)
Completed	7.9
Unsuccessful	2.7
Administrative	3.4

Treatment Level C (Count 3,044)

Discharge Type	Median Length of Treatment (Months)
Completed	8.7
Unsuccessful	2.7
Administrative	3.1

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Table 16. Figure 5 Number of DVOMB Approved Providers by County, FY 2025.

County Name	Count of Providers
Adams County	24
Alamosa County	5
Arapahoe County	29
Archuleta County	1
Baca County	0
Bent County	1
Boulder County	9
Broomfield County	0
Chaffee County	1
Cheyenne County	1
Clear Creek County	0
Conejos County	0
Costilla County	0
Crowley County	0
Custer County	0
Delta County	1
Denver County	40
Dolores County	0
Douglas County	10
Eagle County	0
El Paso County	35
Elbert County	0
Fremont County	17
Garfield County	5
Gilpin County	0
Grand County	1
Gunnison County	1
Hinsdale County	0
Huerfano County	1
Jackson County	0
Jefferson County	27
Kiowa County	0
Kit Carson County	1
La Plata County	4
Lake County	1
Larimer County	10
Las Animas County	1

County Name	Count of Providers
Lincoln County	0
Logan County	2
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	3
Saguache County	0
San Juan County	0
San Miguel County	0
Sedgwick County	0
Summit County	3
Teller County	1
Washington County	0
Weld County	8
Yuma County	1

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Table 17. Figure 6 ODVSOM Shared Services Model and Organizational Chart, FY 2025.

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 & Compliance Review Coordinator	Maija Roscoe
ODVSOM Documentation Specialist	Ellen Creecy
ODVSOM Staff Researcher	Dr. Rachael Collie
ODVSOM Staff Researcher	Dr. Yuanting Zhang
ODVSOM Staff Researcher (0.5 FTE)	Jessica Manrique
ODVSOM Program Assistant	Jill Trowbridge
DVOMB Program Coordinator	Caroleena Frane
DVOMB Implementation Specialist	Reggin Palmitesso-Martinez
DVOMB Application & Compliance Review Coordinator	Brittanie Sandoval

Note: ODVSOM (Office of 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 2025

Executive Committee

Committee Chair: Michelle Hunter. **Committee Vice-Chair:** Erin Gazelka
Members: Det. Sandie Campanella, Honorable Kolony Fields, 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, ARC 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 continued to meet regularly 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: Det. Sandie Campanella. **Committee Co-Chair:** Michelle Hunter
Members: Jennifer Parker, Jessica Fann, Jeanine Anderson, Melissa Hall, Nil Buckley

Purpose: The ARC serves as the delegated arm of the Board that is charged with decision-making authority for applications, complaints, 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 continued to meet monthly for between three to four hours per meeting, either in person or online. The committee reviewed applications, complaints, CAPs, and variances in a timely manner, as well as managed SCRs. Major highlights include:

- The Committee reviewed a large number of applications for candidate level, as well as status upgrades and additional service listings.
- The Committee received 17 new complaints (against 12 providers) and carried over 7 complaints from the prior fiscal year. Fifteen complaints were resolved in FY 2025.
- The Committee managed 10 SCRs and 8 CAPs (from those implemented in FY 2024 and FY 2025).

Future Goals: Continue reviewing applications, complaints, compliance action plans, and variances in a timely and efficient manner. Continue to initiate SCRs on 10% of providers every two years.

Standards Revisions Committee (SRC)

Chair: Erin Gazelka. **Vice-Chair:** Jeanette Barich

The Standards Revisions Committee (SRC), composed of Approved Providers, Supervising Officers, and Treatment Victim Advocates (TVAs), aims to enhance victim safety and improve offender treatment strategies by recommending updates to the *Standards and Guidelines* for the **DVOMB**. Their work incorporates current research and seeks to improve consistency among domestic violence treatment providers and Multidisciplinary Treatment Teams (MTTs).

Main Accomplishments: The SRC focused on revising Section 5.0 (treatment services) and moving the Treatment Contract/Releases of Information to Section 6. Key achievements include:

- **Treatment Phases:** Proposed a three-phase structure: Treatment Readiness and Motivational Enhancement (optional), Domestic Violence Under Treatment, and Maintenance.
- **Duration & Dosage:** Clarified that treatment duration is based on progress and competency completion, not a fixed time.
- **Assessment:** Refined language for the domestic violence risk and needs assessment and discussed the impact of the revision to the DVRNA, rebranded the CASCADE.
- **TPR Flexibility:** Extended the Treatment Plan Review (TPR) period from 2–3 months to 2–4 months.
- **Second Contact:** Developed a guide for Section 5.08 to address co-occurring needs while maintaining the primacy of the provider's clinical judgment.
- **Contracts/Teletherapy:** Addressed public comments on contracts, including a decision to prohibit AI use in client work pending further review.

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

Individually Responsive Care (IRC) Committee

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

Formerly the DEIB Committee, the **Individually Responsive Care (IRC) Committee** is composed of diverse stakeholders (Approved Providers, Supervising Officers, Treatment Victim Advocates, etc.). Its goal is to recommend policy, procedure, and *Standards and Guidelines* updates to the **DVOMB** to ensure **equity and inclusion** by integrating cultural competency, addressing bias, and promoting social justice in service delivery.

Main Accomplishments: The IRC transitioned to a quarterly meeting schedule and prioritized integrating its core principles across the Board:

- **Inter-Committee Representation:** Established a function to place IRC members on other **DVOMB** committees (Standards Revision Committee, Victim Advocacy, etc.) to ensure an IRC perspective is applied across all initiatives.
- **Standards Review (Appendix B):** Began a major review and update of Appendix B (Specific Offender Populations/SOP), focusing on integrating distinctions for female offenders and LGBT+ populations into the Board's philosophy and work products.
- **Cultural Humility:** Developed and implemented four key talking points for representatives to share at other committee meetings to promote awareness of the impact of the work on historically marginalized communities.
- **Language Access:** Reviewed public comments on the Interpretation Appendix, concluding that while native language providers are preferred, standards cannot mandate referrals to Probation.
- **Training & Education:** Two members prepared a conference presentation focusing on privilege and cultural humility for providers, emphasizing self-reflection over compliance.

Future Goals: Continue the Appendix B review, seeking evidence-based research for specific populations. Actively engage with and provide feedback to other **DVOMB** committees to support cultural responsiveness.

Victim Advocacy Committee

Committee Chair: Jessica Fan. **Committee Vice-Chair:** Andrea Bradbury

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 regularly in FY 2025 to integrate victim advocacy into treatment standards and coordinate training. Highlights include:

- **Standards Revisions:** Reviewed and approved moving updated language from Section 7.0 (Victim Advocacy) into Section 3.0 (Guiding Principles) of the *Standards and Guidelines*.
- Victim Clarification Process: Began developing a victim clarification process for domestic violence cases, intended for the new maintenance stage of offender treatment (Section 5.0). The committee stressed this must be a victim-driven, distinct process from Restorative Justice (RJ) due to safety concerns. Discussions focused on ensuring the process benefits the victim and includes safety planning.
- **Restorative Justice (RJ) Review:** Reviewed a staff update on RJ research, emphasizing the need for safeguards and confirming RJ should be viewed as an adjunct service to enhance treatment, not an alternative, given the limited empirical evidence.

- **DVAM Planning:** Organized a two-part approach for the October 2025 **DVOMB** Board meeting: a virtual screening of "The Last Drop" and an "In Her Shoes" interactive event with an LGBTQ+ focused presentation.
- **Training & Development:** Planned and hosted several trainings, including: Civil vs. Criminal Court Referrals; panel discussion on Multi-Disciplinary Team (MTT) roles; training on DV/Sex Offender (SO) crossover issues; and training on Domestic Violence Dynamics.
- **Implementation Support:** Reviewed communication to inform TVAs of Section 7.0 revisions and discussed simplifying **DVOMB** website documents for clearer TVA role information and accessibility

Future Goals: The VAC intends to continue to advance the development of the victim clarification process within the **DVOMB** *Standards and Guidelines*. The VAC will also finalize and execute the planned quarterly trainings (MTT Roles and DV/SO Crossover) and the DVAM presentations.

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, Treatment Victim Advocates, Victim Representatives, and other stakeholders who work together to achieve several training 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 2025. The Committee debriefed the 2024 ODVSOM Annual Conference and prepared for the 2025 conference. 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 individually responsive care considerations 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 representation of victim voices at the ODVSOM conference and continuing to support cultural awareness within training.

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